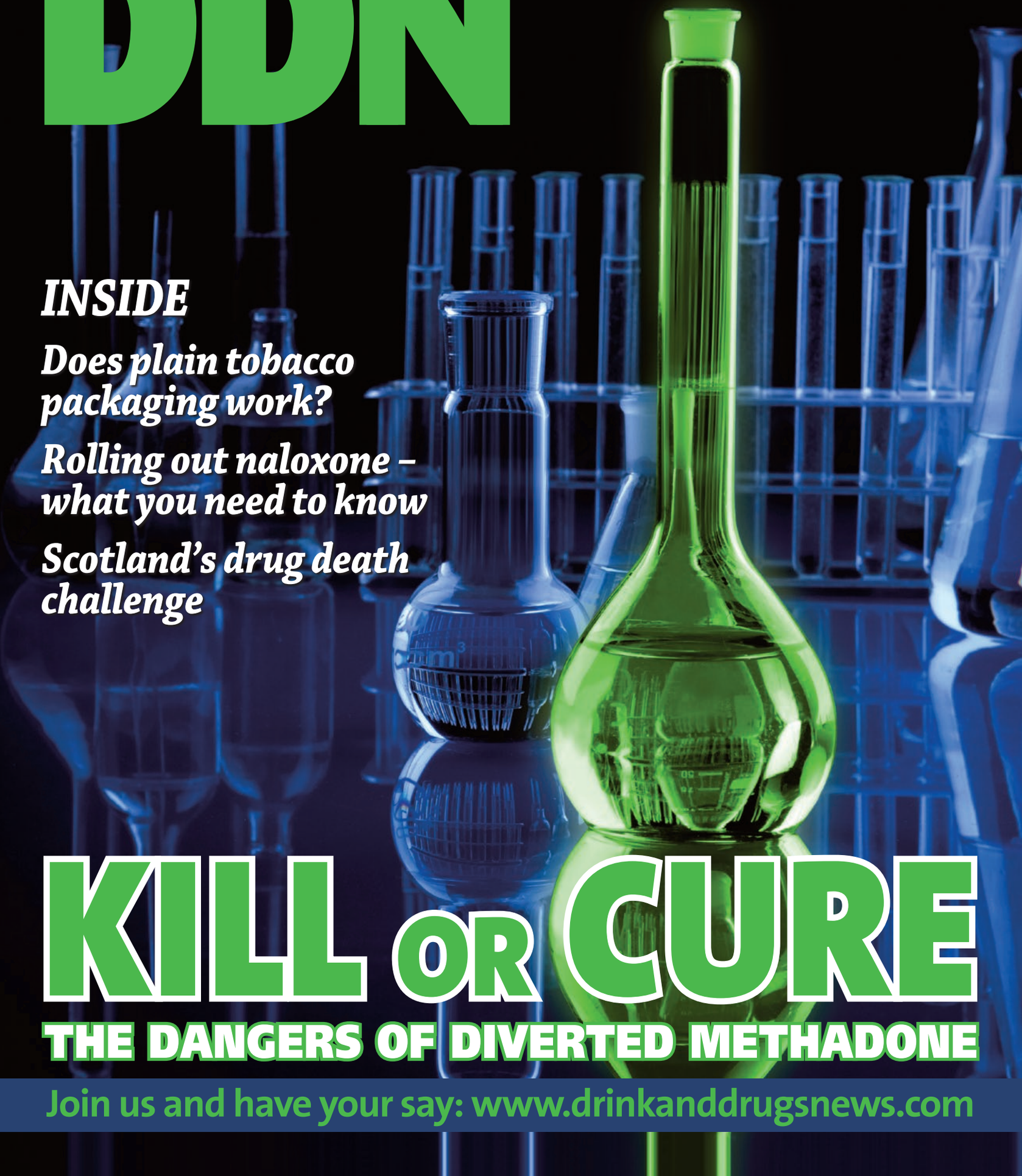
DRINK AND DRUGS NEWS ISSN 1755-6236 SEPTEMBER 2015

DDN



INSIDE

Does plain tobacco packaging work?

Rolling out naloxone – what you need to know

Scotland's drug death challenge

KILL OR CURE

THE DANGERS OF DIVERTED METHADONE

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BIRMINGHAM, 10 NOVEMBER 2015

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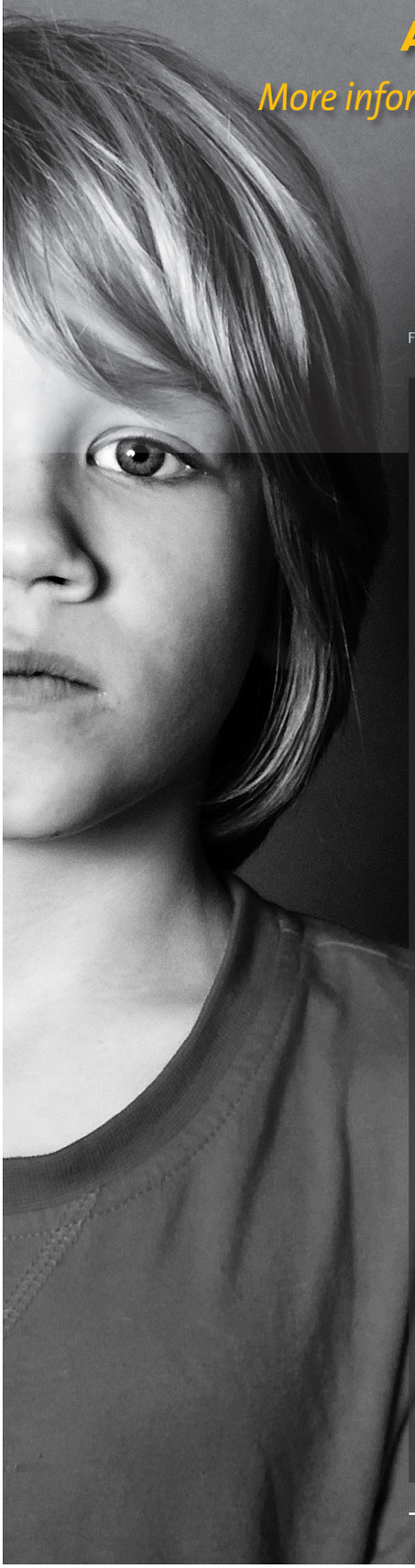

Child safeguarding will always be a priority for everyone coming into contact with families facing substance misuse problems. This one-day event explores ways to improve multi-agency working, and combines practical advice and examples of best practice alongside policy updates.

THE PROGRAMME

9.00 - 10.00am: Registration, tea and coffee

Welcome: **Vivienne Evans**, Adfam

10.00 - 11.00am: **Rosanna O'Connor**, Health and Wellbeing Director, PHE: update on national policy. Emphasising that safeguarding is everyone's responsibility and the importance of multi-agency working.

Joy Barlow, former head of STRADA: 'healthy scepticism', what signs to look out for – aimed at general drugs workers and recovery workers. Defensible decision making, looking at how to keep both clients and their families safe.

11.00 - 11.20am: tea and coffee

11.20 - 1.00pm: Workshops of 45 mins, to be run twice, allowing everyone the opportunity to attend two of the four.

OPIOID SUBSTITUTE MEDICATIONS IN DRUG TREATMENT: TACKLING THE RISKS TO CHILDREN – **Adfam** and **Martin Smith**, Derbyshire Safeguarding Team. Alongside Martin Smith, Adfam will update the data from their April report, *Medications in drug treatment: tackling the risks to children*, as part of a workshop offering advice on training, strategy development and practice improvement for local authorities.

HOME VISITS/ASSESSMENTS – **Sue Smith**, National Safeguarding Lead, CRI. Working with families dynamically: tools for assessments and improving outcomes for both clients and their children.

WORKFORCE DEVELOPMENT – **Carole Sharma**, Chief Executive, FDAP. The need for a well trained workforce, and ongoing assessment.

MULTI-AGENCY WORKING: the challenges and opportunities – **Howard Woolfenden**, Assistant Director, Integrated Services Birmingham, and **Micky Brown**, Safeguarding Lead, Birmingham CRI. Provider and local authority giving their perspectives on partnership working, and looking at developing protocols and building pathways.

1.00 - 2.00pm: Lunch

2.00 - 3.30pm: Panel and closing session

A REAL-LIFE PERSPECTIVE – A personal story, highlighting why safeguarding is important and emphasising that, with the correct support, an individual can turn their life around.

THE PANEL – Using a 'question time' format the panel will address key issues from questions submitted through DDN magazine. There will also be the opportunity for comment and supplementary questions from delegates.

Panel participants: **Sue Smith**, CRI; **Judith Yates**, GP; **Max Vaughan**, Birmingham Commissioner; **Martin Smith**, Derbyshire Safeguarding Team; **Joy Barlow**, formerly STRADA.

CLOSE AND THANKS: **Vivienne Evans**, Adfam

DDN

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EDITOR'S LETTER

'The debate about benefits shows why disadvantage and addiction go hand in hand'

Once again we are confronted with a set of unpalatable statistics: Scottish drug-related deaths are higher than ever (page 4), with the burden falling on 'older' users – older meaning over 35. While this trend is incredibly depressing, the reasons behind it do not point at failure in service quality, but at the victims' lack of engagement with services.

Is this down to funding cutbacks? Lack of proactive outreach? (The first leading to the second?) And could, as David Liddell suggests (page 8), the despair accompanying austerity be adding to people's feeling of ambivalence as to whether they live or die?

The statistics shock us, but the reasons behind them don't surprise us. The ongoing debate about linking benefit entitlements to treatment throws up the full range of inequalities our society has to offer and illustrates all too clearly why disadvantage and addiction go hand in hand.

But consider for a minute Paula's letter (page 16). There she was with everything stacked against her and her addiction leading to prison. What made the vital difference to her life? Those members of staff – those fellow human beings – who believed in her and helped her regain her confidence and her reason for living. 'Is it really so difficult to start some serious joint working' to build recovery communities, she asks.

A thought worth holding onto as we move from last month's 'overdose awareness day' into September's 'recovery month'.

Claire Brown, editor

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SCOTS RECORD HIGHEST NUMBER OF DRUG-RELATED DEATHS EVER

SCOTLAND RECORDED 613 DRUG-RELATED DEATHS LAST YEAR, the highest figure ever, according to new statistics from National Records of Scotland. The figure was 16 per cent higher than the previous year, with three quarters of the deaths among males.

The increase comes after a 9 per cent fall in 2013 (*DDN*, September 2014, page 4), following 2011's record-high figure of 584 and just three fewer the following year. The average age of those dying from drug-related causes has also continued to rise, and now stands at 40 – 12 years older than when recording began in 1996. Sixty-seven per cent of last year's deaths were among the over-35s, with just 8 per cent occurring among those under 25.

One or more opioids (including both heroin and methadone) were implicated in almost 90 per cent.

The figures showed that, while there had been some progress, Scotland still faced a 'huge challenge in tackling the damaging effects of long-term drug use among an aging cohort', said community safety minister Paul Wheelhouse. 'This group of individuals often have long-term, chronic health problems as a result of sustained and, in many cases, increasingly chaotic drug-use issues. We need to better understand the needs of particular sub-groups and to better understand what role the purity, or strength, of illicit drugs is playing in increasing fatalities.'

The statistics were confirmation that the outcomes for drug users 'not engaged in treatment or care' were becoming 'increasingly concerning' added chair of the National Forum on Drug-Related Deaths, Roy Robertson.

'Older drug users are most susceptible because their often frail health cannot sustain a life of poly-substance misuse, including alcohol use, and injecting-related problems,' he said. 'Although the final mechanism of death may be recorded as an overdose, years of high-risk drug use, blood-borne virus infections, smoking and alcohol consumption combine to increase their vulnerability. Stigma, a life course of traumatic experiences, social exclusion and feeling the brunt of austerity leaves many pursuing a risky, hopeless existence, often extinguished ultimately by suffering a drug-related death.'

Drug-related deaths in Scotland in 2014 at www.nrscotland.gov.uk

See news focus, page 8

Paul Wheelhouse: 'This group of individuals often have long-term, chronic health problems as a result of sustained and, in many cases, increasingly chaotic drug-use issues.'

MIXED PICTURE

LAST YEAR, 38 per cent of 11 to 15-year-olds reported that they had tried alcohol at least once, according to figures from the Health and Social Care Information Centre (HSCIC), the lowest proportion since the survey began. While this 'downward drift' was encouraging, however, those who were drinking were drinking more, stressed Alcohol Concern. 'Looking at the broader picture it's a case of more alcohol down fewer throats,' said head of policy Tom Smith.

CHOICE PUBLICATION

A BOOKLET on new psychoactive substances and other drugs has been published by Turning Point, aimed at drug users, their families and professionals. The aim is to educate people to make their own choices, says the charity. 'Substances that are taken in a predominantly recreational context, like novel psychoactive substances, cocaine, steroids and alcohol, place a heavy burden on the health system,' said director of operations for substance misuse, Jay Stewart. 'This new guide aims to provide useful information on the risks associated with substances such as these, to dispel some of the myths associated with certain drugs, and to outline the range of support available.'

A useful guide to psychoactive substances, steroids, cannabis and alcohol at www.turning-point.co.uk

PSYCHOACTIVE CONFUSION

THE PSYCHOACTIVE SUBSTANCES BILL needs to be re-worded in order to avoid 'serious unintended consequences', says the ACMD. While the ACMD broadly supports a blanket ban on NPS it would be 'almost impossible' to list all the desirable exemptions as the controversial bill currently stands, said chair Professor Les Iversen.

BLACK BOOKS

THE GOVERNMENT HAS REIGNITED THE DEBATE over whether benefit entitlement should be linked to accepting treatment, with the publication of its review by Dame Carol Black. The review will look at the 'legal, ethical and other implications' of linking benefit entitlements to the take up of treatment, with a final report to be published later this year.

An independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity at www.gov.uk

E-SAFETY

USING E-CIGARETTES is around 95 per cent less harmful than smoking tobacco, according to a PHE review. The devices can be a useful tool for helping people quit smoking, says the document, with no evidence 'so far' that they act as a gateway to smoking for children or non-smokers. Some commentators, however, have questioned the document's conclusions.

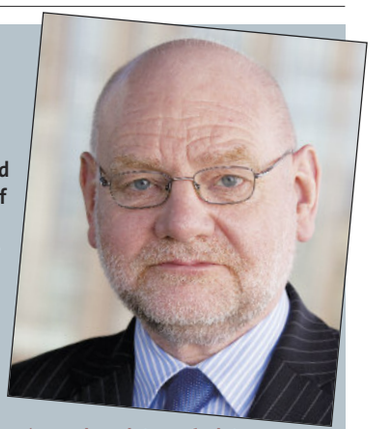
E-cigarettes: an evidence update at www.gov.uk

SUDDEN IMPACT

GOVERNMENT PLANS to reduce the public health grant to local authorities by £200m over the course of the financial year will 'clearly impact' on councils' ability to improve the health of their communities, the Local Government Association (LGA) has stated. 'Giving councils the ability to make a real impact to the health of local people was a positive step, but local government can only continue its important work such as reducing smoking or excessive drinking and tackling obesity if we are adequately resourced to do so,' said chair of the LGA's community wellbeing board, Izzi Seccombe.

GIVING VOICE

A NEW PROJECT that aims to ensure that the voices of service users are properly heard is to be headed by ex-NTA chief Paul Hayes. Collective Voice is a joint venture between major service providers including Addaction, Blenheim, CRI, Phoenix Futures and Turning Point. 'Leadership of this project will require influencing skills, political astuteness and experience of building successful partnerships and links with key stakeholders at the highest level, and the board were clear that Paul Hayes was the outstanding applicant to provide this,' said a project spokesperson.



'Leadership of this project will require influencing skills, political astuteness and experience of building successful partnerships...'

CORNWALL SERVICE USERS CELEBRATE LIFE SKILLS

SERVICE USERS IN CORNWALL have successfully completed a new accredited course, 'life skills in action'.

The course, designed by Cornwall Life Skills, offers skills coaching in education, training, voluntary work and employment – such as developing self-confidence and improving interpersonal skills. Course completion leads to a level 1 AptEd award in progression qualification, which is nationally recognised.

A celebration event was held to award certificates to the ten graduates who completed the course, where they were able to share their progress since finishing it. Other attendees were also given the opportunity to enrol with the service.

Course completion leads to a level 1 AptEd award in progression qualification, which is nationally recognised.

SPECTRUM EARNS PURPLE STAR FOR LEARNING SUPPORT

SPECTRUM, A DRUG AND ALCOHOL SERVICE run by CRI in Hatfield, has been awarded a 'purple star' in recognition of its communication with people with learning disabilities.

The purple star scheme aims to improve relationships between health and social care services and adults with learning disabilities by ensuring all organisations taking part undergo training and service checks to ensure that standards are met.

Spectrum staff took part in specialist training, including how to make their buildings more accessible.

Steve Smith, Spectrum county services manager, said, 'We are proud of our commitment to support everyone who seeks help to improve their health, or that of a loved one. The purple star award is the result of a proactive effort to make sure all our services are as accessible as possible.'

NALOXONE CAMPAIGN LAUNCHED IN NORTH SOMERSET

A 'KEEP CALM AND CARRY NALOXONE' campaign has been launched to help save lives in North Somerset.

Addaction staff in Weston have been offering training on how to administer the life-saving drug, as well as sending participants home with naloxone kits.

The campaign was launched in support of international overdose awareness day on 1 September. 'Lives will be saved due to this training. Taking heroin is a high-risk activity and our service works hard to show people another lifestyle,' said service team leader James Brazier.

'But, while the risk is still happening, users and their significant others should make sure they have a naloxone kit.'

ACORN staff with health and safety manager, Tom Berry (centre)

OLDHAM PROJECT INSTALLS LIFE-SAVING DEFIBRILLATOR

ACORN RECOVERY PROJECTS have installed a defibrillator at their Brunswick House Oldham centre that will be available to both staff and members of the public.

The 'defib' could potentially save the lives of clients, staff and casualties in the wider community, and although no formal training is required to operate it, safety manager Tom Berry delivered training to four Acorn staff at the Acorn Recovery Projects centre.

EDGY PRODUCTION IN EAST LONDON

A NEW PRODUCTION from Outside Edge theatre company uses personal testimonies and live cabaret to explore the 'splintered, chaotic and at times absurdly comic' world of people affected by addiction'. *Rockston Stories* can be seen at Hoxton Hall, east London, from 29 September until 17 October.

The cast have a 'dynamic creative energy, cutting humour, and an infectious desire to share the truth about addiction,' said director Susie Miller. *http://edgetc.org*

PHOENIX RESIDENTS CAN BRING CANINE CHUMS TO REHAB

'Many people in active addiction build strong ties with their dogs... Their dogs give them unconditional love through the worst points in their lives.'

KAREN BIGGS

A BLOCK OF KENNELS has been opened at Phoenix Future's Wirral residential service, Upton Road, to allow service users to bring their dogs along with them to rehab.

The kennels were opened after an increasing number of people with drug and alcohol problems raised concerns that they could not access help as it would mean they would have to give up their pets.

'Many people in active addiction build strong ties with their dogs. Their dogs keep them warm and safe during periods of homelessness, give them unconditional love through the worst points in their lives and a reason to keep going when all other relationships appear irrevocably damaged,' says Karen Biggs, Phoenix Futures' chief executive.

The dogs will be cared for by their owners, trained professionals and others at the service, and the kennels will enable people to live with their dogs while receiving treatment.

BEE-KEEPING PROMOTES RECOVERY

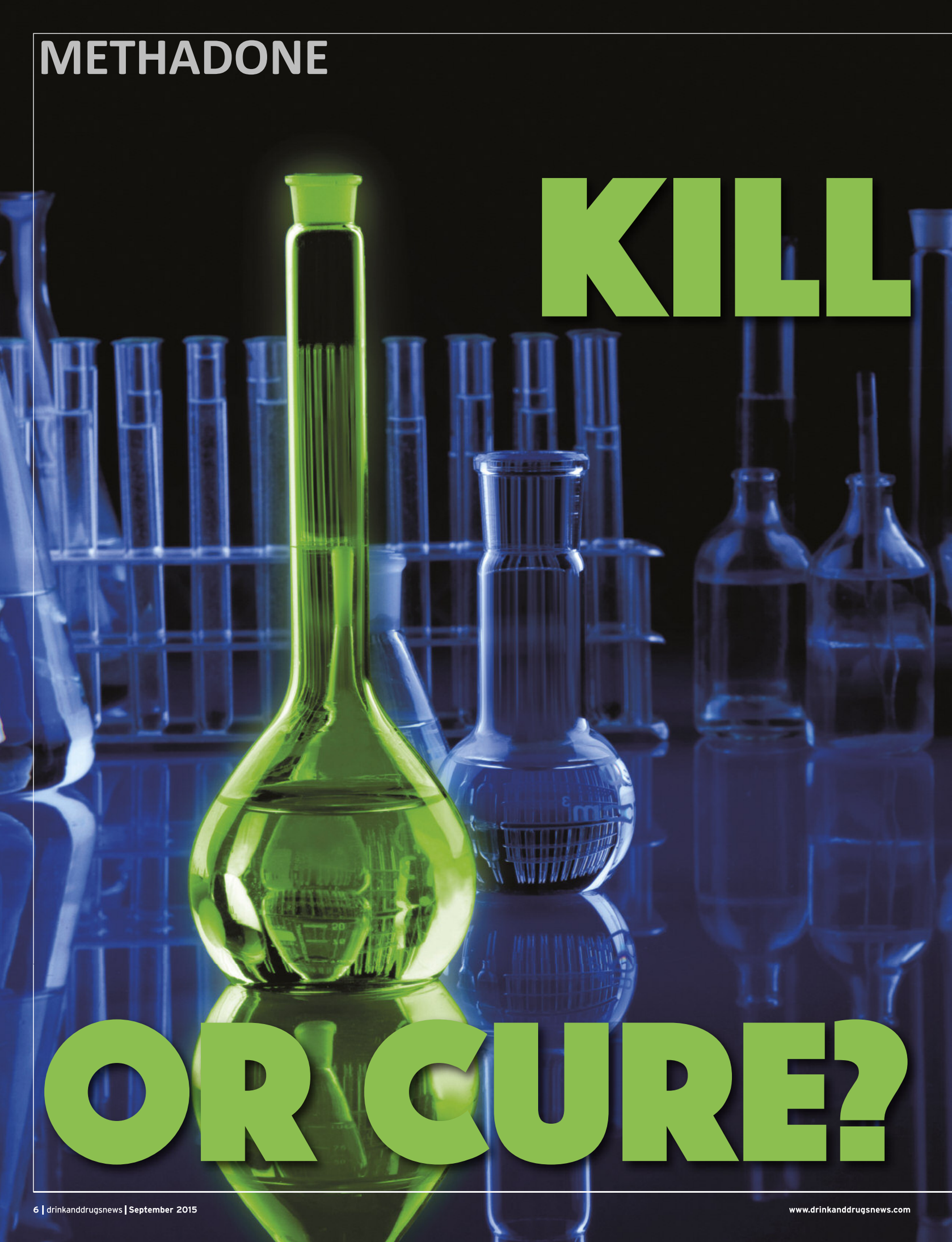
A NEW BEE-KEEPING PROJECT has been launched to promote skills development in Calderdale.

Calderdale in Recovery has received a grant from the Kathleen Mary Denham Fund to purchase hives, safety equipment and the first colony of bees for the project, after the local recovery community was consulted on what kind of project they would like to become involved with.

The aim of the project is to help those taking part develop husbandry skills, with a view to producing 'recovery honey' that can be sold to fund local community-led initiatives.

METHADONE

KILL OR CURE?



Read the full version online at:
www.drinkanddrugsnews.com

Is it time for us to reappraise our relationship with the life-saving drug methadone? **Dave Marteau** discusses the evidence

Since the early 1970s, methadone has been the predominant opioid prescribed in the UK for the ongoing treatment of heroin addiction. It has proved extremely useful in the fight to contain HIV among injecting heroin users, and there is strong evidence that longer-term methadone treatment of heroin addiction reduces death rates by as much as 50 per cent. Moral objections have been voiced by many about a treatment that swaps addiction to one drug (heroin) for dependence on another (methadone), but perhaps we can all agree on the primacy of life itself: it trumps any argument.

In 2007 the then-National Institute for Health and Clinical Excellence (NICE) positively evaluated methadone and buprenorphine. In circumstances where assessments had suggested that both drugs were equally suitable, NICE recommended that 'methadone should be prescribed as the first choice'.

However, in a review of drug-related deaths in France between 1994 and 1998, Marc Auriacombe found that, set within the context of numbers of prescriptions issued, methadone was at least three times more lethal than buprenorphine in respect of overdose deaths within the French population as a whole (*ie*, among patients and the wider public).

On the subject of the relative toxicity of methadone and buprenorphine, NICE had this to say:

'Comparison of data from population cross-sectional studies suggests that the level of mortality with BMT [buprenorphine maintenance] may be lower than that with MMT [methadone maintenance], although other authors have commented that these data were unlikely to capture all related deaths.'

This was a cursory summary of an important matter in 2007; it would be insufficient to the point of negligence now. In 2009 James Bell and colleagues in New South Wales found that, per prescription, methadone was 4.25 times more lethal than buprenorphine. This year Rebecca McDonald, Kamlesh Patel and I carried out a similar but larger study in England and Wales. We found that between 2007 and 2012, 57 death certificates mentioned buprenorphine, while 2,366 death certificates mentioned methadone.

Allowing for a calculation that seven methadone prescriptions were issued for every buprenorphine prescription, methadone emerged as six times more dangerous across the population as a whole. The picture in Scotland appears no prettier. Between 2011 and 2013, heroin and its metabolite morphine were implicated in 538 drug poisoning deaths; methadone was found to be implicated in 663 deaths.

So how is it that a drug with the potential to halve a patient's risk of dying ends up killing so many people? The answer is horribly simple: while most patients are safer on methadone, the wider population are at continued risk from diverted supplies of the drug. The National Programme on Substance Abuse Deaths found that of 1,117 UK deaths that involved methadone alone or in combination with other drugs, only 36 per cent occurred among individuals who were known to be receiving methadone treatment.

To be fair to NICE, their methodology was designed to determine the cost-effectiveness of a drug, not its safety. That same methodology, based solidly on randomised controlled trials, compares the outcomes for a patient group on drug A with those for members of a patient group on drug B. No persons outside of these two groups are considered. This is a very good means to evaluate antibiotics or chemotherapy, but altogether less suitable for drugs intended to treat people with a drug-taking problem. No one on antibiotic 'A' would be likely, for instance, to consider trading their medication with a non-patient, or to be put under duress to hand over their medication outside the pharmacy.

There is another stark statistic: of all drugs detected at post-mortem over the past three years in Scotland, methadone has, at 93 per cent, the highest degree of implication in the unfortunate person's death. So, if you were to die from a drugs overdose, and methadone was among the substances found in your body, there is a 93 per cent chance that it had been wholly or partly responsible for your death. This makes methadone significantly more toxic than heroin, (which had an implication rate of 83 per cent), buprenorphine (65 per cent) and cocaine (63 per cent). Put simply, methadone is the most dangerous drug out there.

Methadone has the capacity to retain more people in treatment than buprenorphine, but the evidence is now overwhelming that it is significantly more lethal. Hundreds of our fellow UK citizens are dying every year from methadone poisoning. If we agree with the premise at the start of this article that the value of life prevails over any other argument, then we have now to relegate methadone to a secondary option for the substitute treatment of opioid dependence, behind buprenorphine and buprenorphine-naloxone. Failure to change would indicate that we are less courageous than our clients in confronting a dangerous pattern of our own behaviour.

For the record, I have never taken nor will ever take a penny from a drug company.

Full references accompany this article at www.drinkanddrugsnews.com
Dave Marteau is research fellow at the University of London

'How is it that a drug with the potential to halve a patient's risk of dying ends up killing so many people? The answer is horribly simple: while most patients are safer on methadone, the wider population are at continued risk from diverted supplies of the drug.'

STARK STATISTICS

Scotland has recorded its highest ever number of drug-related deaths. **DDN** looks at what's behind this bleak trend, and what could be done to reverse it

Last year there was cautious optimism when figures showed that the number of drug-related deaths in Scotland fell by just under 10 per cent in 2013. Admittedly, this followed 2011's record high of 584, a figure almost unchanged in 2012, but many still hoped that the tide had finally turned.

Those hopes were dashed last month when the 2014 statistics from National Records of Scotland were released, recording the highest death toll ever, at 613. Once again, the vast majority were older drug users, with 67 per cent of deaths in the over-35s. 'I think within the whole sector there was a feeling of depression that the figures were going up again, and a realisation that it's likely the trend is still upwards,' Scottish Drugs Forum director David Liddell tells *DDN*.

As well as being older, the majority of those dying appear not to have been engaged with services at the time, raising questions not only around access, but also about what should be done 'for those falling out', he says. 'Should we be doing more in terms of assertive outreach and looking at other models to chase people up?'

With services already under intense pressure, changing approach to become even more proactive is going to be a challenge, he acknowledges. 'But I think it's definitely something we need to do. The other thing that links into that, knowing what we know about the protective factors of treatment, is that in Scotland we've probably got half the population of 60,000 [problem drug users] in treatment. In countries like Switzerland and Holland it's much higher, and that's what we should be aiming at.'

On the subject of pressures, some have commented that government cuts and austerity measures will have played a role in the increased number of deaths. Is that something he'd go along with?

'I'm only cautious in the sense that it's very difficult to prove that,' he says. 'But certainly what we have with the older group is a group that came out of the 1980s and mass unemployment and austerity, so what we're seeing is that same group being hit by a second wave of austerity now. Clearly that's having an impact. Whether it's adding to people's ambivalence as to whether they live or die, and those whole feelings of despair – I'm sure that's the case, but it's very hard to quantify.

'More generally, in terms of service cuts, we've been very fortunate in Scotland in that core funding for specialist health services has been ring-fenced for many years,' he continues. 'It hasn't kept pace with inflation, but it's largely been untouched. But some of the wider services, particularly within local authorities, have obviously been hit. I'm sure it's had some impact.'

It's been pointed out that older drug users perhaps haven't been as much of a priority, because they don't tend to be as involved in acquisitive crime. Is that focus starting to change? 'It has to, just because of the profile of the population in services,' he states. 'There has been that sense that you've had a group who maybe weren't creating significant demands, but I think services do need to pay more attention.'

However, it's important not to lose sight of the fact that deaths in under-35s have actually remained fairly constant over the last couple of decades. 'It was interesting in that the narrative was that the deaths had continued to fall in the younger age group as a percentage, but certainly when we looked at the actual figures they were up,' he says. 'In the 15-24 group they were up by 14 on the previous year, and for 25-34 they were up by 19.'

Here lies the challenge around the aging cohort narrative, he stresses. 'It's true in overall terms, but there are still younger people developing drug problems and of course you still have a large group of vulnerable young people. So sadly it shouldn't really come as any surprise.'

It also highlights the importance of continuing to pay attention to the emerging population, he says. 'It's not an easy balance, but certainly it's a wake-up call. We can't just adapt our services to an aging cohort then realise that there's a younger group that have opted out of services because we're not meeting their needs.'

As he's pointed out, little has changed for that older cohort over the last three decades. Is it becoming more accepted that problem drug use is largely the result of poverty, or is the dominant message still the opposite?

'I don't think it's largely recognised, beyond people who work in the area or are more widely involved in health policy,' he says. 'I just did an article in the *Edinburgh Evening News* and got a particularly vicious email response, basically saying these people should be left to die. I was talking about underlying problems such as trauma, on the basis that a lot of the public narrative is around lifestyle choices and so on. It's about trying to get people to understand that the folk who are dying are actually victims of society, by and large – they've had a raw deal, their drug use is largely a way of coping with the hand they've been dealt, and they deserve a bit more public sympathy. But clearly that's an uphill struggle.

'Our government has been hugely supportive in trying to reduce drug-related deaths, but you do have to think that if there were 600 deaths in any other area, there'd be a public outcry. It's a sad state of affairs, but it's the reality.'

'It's about trying to get people to understand that the folk who are dying are actually victims of society, by and large – they've had a raw deal, their drug use is largely a way of coping with the hand they've been dealt, and they deserve a bit more public sympathy.'

DAVID LIDDELL

Formerly known as Intuitve Recovery

Intuitive Thinking Skills™

From dependence to Independence

CHALLENGING ATTITUDES

A decade of experience has shaped Intuitive Thinking Skills' successful approach to attitude change, as **Peter Bentley** explains

IN 2003, I was coming to the end of a week-long alcohol detox in Manchester's Smithfield Centre. I was determined to never return there and it was apparent to me that the best way to ensure that was to stop drinking and using drugs for good.

I got a fabulous detox, professionally delivered and with a refreshingly short waiting time to start. What happened afterwards however was far less impressive.

Newly detoxed, I leapt into the post-detox services that were available in 2003. These were pretty much exclusively the fellowships and a kind of quasi fellowship daily support model. There was a unifying thread that ran through all the services then – namely that you were a patient, that 'treatment' would take a long time and that there were no guarantees. This was when I was first told that I had a 'relapsing condition', that people rarely conquered the problem and that I should not give myself a hard time if I failed.

What was happening in front of my very eyes was the state trying to replace substance dependency with service dependency, and to this day I have proudly railed against the duplicity of this.

So here we are, ten years on, and in May 2015 Intuitive Recovery changed its name to Intuitive Thinking Skills to celebrate its anniversary and to reflect on the increased number of courses we deliver across the UK.

We realised our speciality was attitude change, whatever that attitude may be. Dependence is a curious word, often used to justify the place that a person is in rather than the solution to help move them on. All our courses are designed to enable a person to gain independence – not just from their own negative behaviours but also from public services they are engaged with.

We believe we are a truly unique organisation, entirely peer-led and promoting abstinence, education, training, employment and self-determination within our learners. The fact that we have been there and got the T-shirt means that we deliver hard-hitting, no-nonsense education which cuts through the treatment and recovery jargon that has become so prevalent.

Our staff are all graduates of our programmes and have left services, fully 'recovered', employed and enjoying the world of work and all the benefits it brings.

The message? Change looks and feels great and is entirely do-able.

BELIEFS

Whether it is beliefs and attitudes that support future substance use, inactivity in employment and education, or negative attitudes to community engagement, our programmes all target these beliefs, presented as negative thoughts, outlooks and attitudes and allow learners to see that they create their own obstacles through their learned thought patterns.

Once people learn that we all have negative thoughts and that we are all selective in choosing which of these we act upon, change becomes easy. After a little practice, the new set of choices becomes second nature.

OUR PROGRAMMES

INTUITIVE RECOVERY

An accredited educational programme that promotes abstinence as achievable and easy to maintain. Delivered over six sessions, it provides skills and tools to recognise and control addictive desires and to take responsibility for choices, behaviours and change. Install a plan to never use again; it feels great to know you will never go back.

SKILLS-TU EMPLOYMENT

Our accredited educational course designed to skill people into employment. The course targets attitudes of dependence on state benefits and low or unrealistic aspirations regarding future employment. We deliver in a classroom setting over a short yet intensive period with follow-up sessions supported by sensible yet challenging targets.

THINKING COMM-UNITY

Thinking Comm-Unity is an educational course aimed at improving any individual's knowledge, sense of belonging and understanding of their community. By recognising and valuing each person's skills and abilities, we demonstrate how these can be coordinated to give people the power and responsibility for their future.

The course helps to identify how attitude, knowledge, skills and abilities can affect not only your life but the lives of those around you. By examining different types of communities, we gain an understanding of the importance of diversity. Through community-focused personal development, we achieve our goals while overcoming challenges and helping to improve the lives and wellbeing of others.

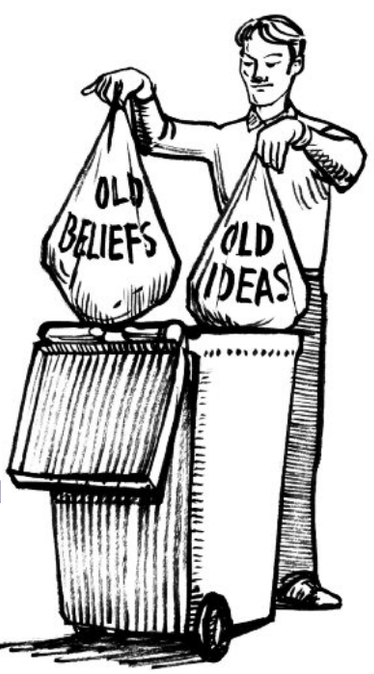
KEY INTERVENTIONS TOOLS

KIT training offers a simple and effective tool aimed at complementing or refreshing the knowledge and skills of professionals, volunteers or mentors. In fact this is for anybody wishing to gain insight and wanting to improve their work with individuals involved within drugs and alcohol, back to work, criminal justice and social housing sectors. The key objectives of this training are to both raise insight and awareness and encourage independent action towards abstinence, desistance, rehabilitation and employment. Partnership focused, we bring together key stakeholders within an area and look at how system-wide structures can cause blockages and obstacles for our shared service users.

Peter Bentley is managing director at Intuitive Thinking Skills

For more information, visit www.intuitivethinkingskills.com or email info@intuitivethinkingskills.com

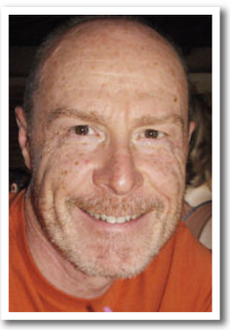
'The fact that we have been there and got the T-shirt means that we deliver hard-hitting, no-nonsense education which cuts through the treatment and recovery jargon that has become so prevalent.'



Intuitive Thinking Skills – The Specialists in Attitude Change

Much more on Naloxone at:
www.drinkanddrugsnews.com

READY FOR ACTION



Naloxone is to be made more readily available next month. Public Health England's **Steve Taylor** looks at how local services and commissioners can respond to this change in the law

LEGISLATION to allow naloxone to be more widely available for those who need it is on track to be enacted next month. This follows the Advisory Council on the Misuse of Drugs (ACMD)'s recommendation in 2013 and a public consultation by the Medicines and Healthcare products Regulatory Agency in 2014 that saw wide support for the proposals.

The evidence shows that take-home naloxone given to service users, and training family members or peers in how to administer naloxone, can be effective in reversing heroin overdoses. Because it is only available as an injectable product, naloxone will remain a prescription-only medicine but the legislation will permit people working in commissioned, lawful drug treatment services to supply naloxone without a prescription to anyone needing it to prevent a heroin overdose.

Drug treatment services are generally seen to be those providing specialist services, primary care drug treatment, and needle and syringe programmes (including pharmacy-based programmes).

These services will legally be able to order naloxone and their staff will be able to supply it to individuals without needing a prescription or any other written instruction from a health professional. These individuals could be drug users themselves, or it could be family members, friends, carers or hostel managers who may need easy access to the medication.

Services that work with drug users but do not provide drug treatment would be unlikely to count as lawful drug treatment services, so would not be able to supply naloxone according to the new proposals. However, these services could arrange for people to visit another service that does supply naloxone or, using existing mechanisms, could ask a doctor to prescribe naloxone if the individual has been identified as at risk of overdose.

The legislation is about supply to individuals, so a drug treatment service will not be able to supply stocks of naloxone to another service.

Preliminary advice from the working group updating the 2007 clinical guidelines on drug misuse and dependence clarifies appropriate naloxone dosing in the case of an overdose, naloxone products that can be supplied, and training that should be provided.

Once legislated, commissioners will need to agree how any new naloxone supply works locally, including:

- *What naloxone product should be supplied and how it should be packaged, if needed, to include one or more needles and a sharps box.*
- *Which services will be funded to supply naloxone.*
- *Which groups of people should be able to receive naloxone.*
- *How these groups might be prioritised and whether there is any limit on how much naloxone can be supplied.*
- *What record keeping is required to track supplies and arrange for re-supply.*
- *What training should be provided alongside naloxone.*

PHE's advice earlier this year – *http://bit.ly/1G37cz9* – covers many of these points and PHE is now considering what further resources would be helpful to commissioners before October's legislative change.

Steve Taylor is programme manager, alcohol, drugs and tobacco division, health and wellbeing, Public Health England

FACT FILE

What is naloxone?

Naloxone is an emergency antidote to opiate overdose. It blocks opioid receptors to counteract the effects of opioid drugs (such as heroin, methadone and morphine), reversing the life-threatening effects of an overdose such as depressed breathing.

How do you administer it?

It is important first to call an ambulance, check the person is breathing and put them in the recovery position. Then simply attach a needle (if not already fitted) to a pre-filled syringe or minijet and inject the overdosed person in a large muscle (thigh, buttock or top of the arm).

Is it harmful?

Naloxone itself has no psychoactive properties and 'no intoxicating effects or misuse potential'. It is injected directly into the body so is quick to take effect.

Does it encourage risky behaviour?

Surveys of people who use opiates suggest this is not the case. As naloxone works by inducing rapid withdrawal from opioid drugs, its use is likely to be something that people who use these drugs are keen to avoid.

From PHE advice

More good practice stories at www.drinkanddrugsnews.com

GOOD SPORTS

Pat Berry and **Ron Bell** talk about how they help service users improve their wellbeing and build self-confidence from exercise

Playing sports on a regular basis requires discipline, which builds much needed structure into daily life. Being part of a group of like-minded peers, and the natural high gained from exercise, may help raise self-esteem – a key component of good social interaction.

The relationship between sport and improved mental and physical wellbeing is well established. The key is to get people with complex care issues to participate in these positive activities.

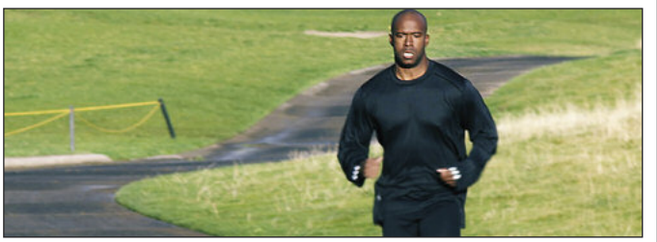
The uniqueness of Sporting Recovery is the combination of team and individual sporting activities and lifestyle advice (SMART Recovery) along with the opportunity for clients to gain nationally recognised sports qualifications. As an evidence-based exercise programme, we support adults on their recovery pathway back into their communities.

We focus on people who are marginal, high risk and hard to reach, who often have concerning co-morbidity problems. These adults have difficulties accessing, trusting and re-engaging with traditional services.

The hardest part of any exercise course is starting, particularly when you've been inactive for a prolonged period. To overcome this inertia, our programmes are available in the form of transferable season tickets, with the first six sessions free to encourage participation.

We are keen to support successful treatment completions and recommend that service users attend the exercise programme for 42 sessions. The sessions are weekly and include a free lunch, with the opportunity to obtain voluntary and paid work within, and outside, Sporting Recovery.

We believe that if we provide a safe, friendly and fun environment we can engage these hard to reach adults. The first thing is to treat them like regular people with the same desires to enjoy and succeed in their chosen sport. The focus is on self-development and inner peace – something we all need!



The key is to get people with complex care issues to participate in these positive activities.

Pat Berry and Ron Bell run Sporting Recovery, www.sportingrecovery.org.uk

DRINK SMART

Jesse Wilde shares results from three city-wide schemes aimed at reducing the supply of high strength beers and ciders

The Brighton 'sensible on strength' scheme started in November 2013, to reduce the availability of cheap super-strength beers and ciders. Equinox Brighton's street drinking audit in July 2013 counted 93 street drinkers over one week – the worst hotspot had up to two dozen street drinkers, with incidents of anti-social behaviour. Before 'sensible on strength', we regularly saw people consuming alcohol up to 9 per cent ABV.

The scheme has several key partners – Brighton and Hove City Council public health, Equinox Brighton, Sussex Police, street drinkers and alcohol retailers.

'Since launch, 123 retailers have signed up, and 82 per cent of high profile street drinkers now drink alcohol below 6 per cent ABV,' said Tim Nichols, the council's head of regulatory services, on the scheme's impact. 'Equinox Brighton's July 2014 audit showed a 22 per cent reduction in street drinking since July 2013.'

When Suffolk's public health team piloted 'reducing the strength' in 2011, Ipswich had 75 street drinkers and 40 per cent of violent crime was alcohol-related. There were four murders in 18 months, and street drinkers were suffering from ill health.

By December 2014, 100 out of 148 alcohol retailers in Ipswich had voluntarily removed beer, lager and cider above 6.5 per cent ABV. By March 2015, 14 street drinkers remained. Key principles to improve success have been to increase enforcement, reduce supply and improve routes out of street drinking.

'One hundred of 184 off-licences in Portsmouth have signed up, and street drinkers have decreased by 39 per cent over 12 months.'

Portsmouth City Council launched 'reducing the strength' in 2013. According to community safety project officer Robert Anderson-Weaver, 100 of 184 off-licences in Portsmouth have signed up, and street drinkers have decreased by 39 per cent over 12 months. A key breakthrough happened in 2014, when a retailer removed super-strength products from 20 Portsmouth stores.

In all three cities, the challenge is now to achieve consistency city-wide, and to encourage as many retailers as possible to sign up to the schemes.

Jesse Wilde is senior business and partnerships manager at Equinox Brighton. www.equinoxcare.org.uk

More harm reduction at:
www.drinkanddrugsnews.com

Photo: Nigel Brunsdon

HANDS ACROSS EUROPE

It's an exciting time for activism and advocacy among people who use drugs, says *Mags Maher*

FOR THE FIRST TIME IN YEARS, Europe has been able to gather together an experienced group of advocates to form a motivated, innovative and forward thinking activist group interested in implementing harm reduction policy and practice across the EU. The group is called The European Network of People who Use Drugs (EuroNPUD).

We began in 2010/11 when EuroNPUD received €20,000 for a network mapping and case study project from the EU. After a planning meeting at the International Harm Reduction Conference in Liverpool in 2010, we began the project, with a consultant mapping out the range of drug user groups in Europe. Information from this was presented to the European Harm Reduction Conference, held in Marseille in 2011.

EuroNPUD reflects input from 14 countries from across the EU, whose advocates and networks bring a range of different experience and expertise. Many of our leading activists and members are well-established players in the world of drug policy, harm reduction and community mobilisation among people who use drugs (PWUD).

Drug-related activities are the core focus of our organisation and include drug-demand reduction, supply reduction, international cooperation, information, research and evaluation. We have also established communication systems among drug user groups and activists in the EU, as this is key to our intelligence gathering and consultation at grass roots level.

EuroNPUD is already engaged in domestic advocacy and we have members with experience of representation at both EU and UN meetings. One of our key targets will be the development of an EU advocacy strategy, and our members are involved in many best practice projects looking at responses to overdose, HIV and viral hepatitis. We have a clear mandate around drug law reform.

Western Europe has a tradition of drug user activism dating back to the 1970s that reflects the diversity of drug taking and drug-related cultures. The European HIV epidemic in the 1980s and 1990s saw people who inject drugs organising together, while the development of opioid substitution therapy (OST) services also led to a consumer rights movement. As networks have matured there has been strong collaboration between different types of drug users, leading to national policy-making, advocacy and lobbying for drug law reform.

EuroNPUD will be actively engaged in the planning and preparations for the UN General Assembly Special Session on Drugs (UNGASS) 2016, where the global community will have the opportunity to consider decriminalising people who use drugs. Whether this goal is achieved or not, this drug policy summit meeting will provide a key milestone in the global dialogue about drug control regulations.

We will also support the UNAIDS and co-sponsors push to end the HIV epidemic by 2030, actively promoting the nine core harm reduction interventions recommended by WHO, UNAIDS and UNODC in the technical guide on HIV and injecting drug use across EU countries.

EuroNPUD is mindful of new drug trends, such as novel psychoactive substances, and will be supporting the development and dissemination of learning and best practice in these areas. We will also promote the meaningful participation of PWUD in drug policy discussions, the review and development of drug treatment systems, and the continuing public health agendas around HIV, TB, and viral hepatitis. We are aiming to hold an international campaign over the Christmas period promoting access to naloxone, and are hoping to engage the UK's dedicated drug user activists in this.

> 'EuroNPUD reflects input from 14 countries... whose advocates and networks bring a range of different experience and expertise.'

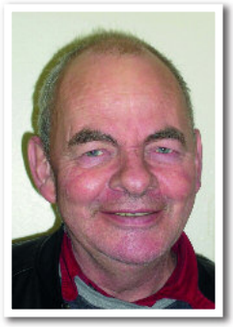
In short, we hope that EuroNPUD provides a pathway to draw on national experiences and expertise among drug user groups, in terms of both identifying best practice and highlighting current gaps in service. Through a steering group representing members from 14 countries, we now have a mechanism to consult and gather intelligence and testimony from those directly affected by drugs policy and practice.

Mags Maher is coordinator of EuroNPUD

Read the full stories and more, online
www.drinkanddrugsnews.com

CAUSE AND EFFECT

Last issue, we reported on a set of guidelines about supporting those bereaved through drug and alcohol related death. **John Rossington** looks at how a personal loss can in turn lead to addiction



I HAVE BEEN EMPLOYED in the substance misuse field for many years and I have always been struck by how often bereavement has been the precursor to a period of active addiction to drugs or alcohol. Two years ago, I was propelled into the nightmare world of bereavement and was given insight into how personal loss and society's reaction to such loss leaves an individual so vulnerable.

I have never had a family to speak of and for 20 years, I lived with my soulmate Michael. On 9 March 2013, I returned from work in the evening and found him unconscious on the sitting room floor. By 10 o'clock that night he was dead.

In an instant my life had changed completely and I had been tossed into a world of complete isolation. It felt as if the world was embarrassed by my grief and turned its back on me.

When I eventually returned to work, emotionally drained, I was stung by most people's reactions. It was clear that most of my colleagues wanted not only to ignore Michael's death, but to wish away his very existence.

We must ask ourselves why we have reached such a state in society where we are unable to engage in each other's pain and provide comfort to those in distress. If we cannot address this, then many others will mistakenly seek comfort in the oblivion of drugs or alcohol.

> Personal loss and society's reaction to such loss leaves an individual vulnerable.

Michael's death and people's reaction to it have changed me. For the first time in my life outside of work, I am quite reclusive. I worry that I am a nuisance to other people.

There are signs of hope. I am impressed by how so many people in the recovery community are committed to creating meaningful communities where we engage with each other in a supportive and nurturing way.

In the meantime, I take some comfort in the fact that I have not succumbed to addiction and hope that I can be more effective in supporting others for whom profound loss has been the cause of their drug or alcohol issues.

John Rossington is manager at Big Life Pathways Drug and Alcohol Service

FROM OUR FOREIGN CORRESPONDENT

Too scared to prescribe

Dr Chris Ford finds that in the US, new restrictions have had negative consequences for patients in pain

> 'It is critical that we understand this problem and avoid falling into the trap that the US has set...'

I WAS RECENTLY DISCUSSING the increase in use of prescription opioids in the UK and the US with Alex, an American doctor, who specialises in pain treatment, and was shocked to learn of the negative consequences of Drug Enforcement Administration (DEA) restrictions.

He told me about his patient John, who had returned from Iraq in 2013 in 'a very bad way. He had lost both legs and part of his left hand, as well as having internal injuries and severe depression. John was very determined and progressed well in rehab, became mobile and his mood began to lift. But the thing that didn't really improve was his pain – until we hit on hydrocodone. With his pain under control, John was able to continue his rehabilitation, start a part-time job and even began to play football.'

Then Alex told me the regulations around hydrocodone had changed – and so did John's life. He had regulated his own intake, but always within the parameters of the prescription. His pharmacist was now nervous of the new regulations and wanted John to go to another pharmacy. This unsettled John and he again became suicidal.

Alex explained that it is now much harder for him to prescribe opioids, leading to a dramatic reduction in his ability to provide appropriate care for patients in pain. Add to this the increasing restrictions on pharmacies in certain states – in some areas DEA agents have visited pharmacies to review the quantity of opioids being dispensed.

The DEA say they are 'simply enforcing the law, taking bad people off the street and, essentially, trying to interrupt the supply of illegal prescriptions,' but take no responsibility for the effect on people who need these medications.

So what's happening in the UK? Prescription opioid dependence is a growing problem here and best-practice management is not well defined. In 2013, 757 people died with a prescription opioid in their blood stream, almost the same number as for heroin and illicit morphine (765) and more than for methadone (429). It is critical that we understand this problem and avoid falling into the trap that the US has set for the people caught up in this situation.

Dr Chris Ford is clinical director of IDHDP, www.idhdp.com. Full version at www.drinkanddrugsnews.com

the centre for Public Innovation
working together | delivering change

Mark Napier talks to DDN about the emergence of the complex problem of novel psychoactive substances, and some responses that commissioners and providers can adopt to tackle this issue

A NEW PROFILE OF DRUG USE IN PRISONS

HEALTH NEEDS ASSESSMENTS

The Centre for Public Innovation (CPI) has been involved in research and supporting the commissioning of substance misuse services since its inception in 2000. The company is a social enterprise with more than a decade of experience working in the field of substance misuse, both with commissioners and providers, helping them to understand their clients and provide better services.

Recently, we completed a series of health needs assessments (HNAs) for a number of prisons, on behalf of NHS England. As with all HNAs, there was much interest among commissioners and prison staff with regard to substance misuse – in terms of the need for treatment and the profile of the drug-using population in prison.

CPI were able to bring together a mix of specialist knowledge of substance misuse treatment, along with in-depth knowledge of how prison healthcare works, alongside robust research skills to help explore the issue of substance misuse.

NOVEL PSYCHOACTIVE SUBSTANCES

Having completed prison HNAs on many other occasions, the CPI research team were struck by a pronounced shift in the findings on this occasion, as compared to work we had done previously.

From the outset, it was clear that the use of novel psychoactive substances (NPS) was an issue that the HNAs needed to cover. NPS is the catch-all term for a raft of new and emerging drugs that cover 'legal highs' to recently banned substances and club drugs.

Prison staff reported concerns about the impact of NPS on the health of prisoners, citing a rise in aggression and other behavioural changes among inmates. Healthcare providers were concerned about the demands that NPS were perceived to be putting on their services as well as the need to send prisoners to A&E following apparent adverse reactions to NPS.

Prison professionals were united in their assessment that the use of NPS was a significant and growing problem that had yet to be fully understood.

THE PRISONER'S PERSPECTIVE

In consultation with prisoners, there was a clear consensus that NPS were now the 'drug of choice' and that their use had overtaken that of other drugs, including cannabis.

Some prisoners interviewed by CPI researchers reported that use of NPS was driven partly by mandatory drug testing. Knowing that NPS could not be detected via existing tests, using NPS enabled them to consume drugs whilst working around the prison system.

What was striking was that, while prisoners were well aware of the use of NPS, they were as unclear about the nature of NPS as prison professionals. Whilst prisoners referred to 'Spice' it was clear that this was being used as a catch-all term to describe a range of new drugs with a variety of properties and effects. In essence, prisoners were consuming unknown and untested psychoactives.

DEFINING THE PROBLEM

The picture that emerged from the HNAs was of a rapidly changing shift in the use of drugs in the prison but with little hard evidence to determine the impact that NPS were having. Existing systems were not geared to collecting data on NPS. In the absence of data, responses were ad hoc, driven by anecdotal assessments, and lacked a basis upon which to determine what was and what was not effective.

The National Offender Management Service is aware of the issue of NPS and is undertaking research to create a substantive evidence base for use in the prison system, but this work will take some time to report.

'Understanding about the nature of NPS and how treatment should respond to these drugs is still emerging. The work of CPI can provide some immediate steps that commissioners and providers can consider...'

MARK NAPIER

WHAT CAN BE DONE?

Until the NOMS research is available, CPI determined that a number of steps could be undertaken immediately to start responding to the problem:

- *Prison healthcare providers should record any health incident in which NPS is felt to be a causal or associative factor – either where use of NPS is self-reported or determined by health staff*
- *Prison healthcare providers should follow Public Health England guidance advising that the appropriate response is to address symptoms rather than the specific drug*
- *Substance misuse treatment providers should seek to understand the extent to which their clients are using NPS*
- *Substance misuse treatment providers should determine the extent to which existing provision can be adapted to meet the needs of this group of drug users*

Understanding about the nature of NPS and how treatment should respond to these drugs is still emerging. The work of CPI can provide some immediate steps that commissioners and providers can consider, while the evidence base develops to determine the nature of the issue and how best to manage it.

Mark Napier is managing director of the Centre for Public Innovation (CPI). For more information about how CPI can help your organisation, visit www.cpi.org.uk or call 020 7922 7820

CPI exists to help public and third sector organisations improve the lives of their clients

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PLAIN TALK

Has tobacco plain packaging actually worked, asks Neil McKeganey

SINCE ANNOUNCING IN 2012 that all tobacco products had to be packaged in plain form, bearing large graphic health warnings, but with no brand imagery, the Australian government has been under a legal requirement to provide a review of the impact of the policy.

The clear aim of the plain packaging policy was to reduce smoking prevalence by – reducing the appeal of branded cigarette packs to young people, by removing the brand imagery that might make it that much harder for smokers to quit their habit, and by removing the various logos and colouring that might convey the impression that some cigarettes are less harmful than others.

Siggins Miller, a private consultancy firm funded by the Australian government to contribute to the review, has been carrying out a survey of Australians asking them about their views of plain packaging. But the Siggins Miller review is all about what people think plain packaging may have achieved in changing smoking perceptions, rather than assessing whether it has worked to reduce smoker numbers.

Professor Simon Chapman, one of Australia's leading tobacco control advocates and a bullish supporter of plain packaging, has stated that plain packaging 'might well function as a "slow burn", distal negative factor against smoking, [rather] than as a precipitating proximal factor.'

Dr Olivia Maynard, one of the UK's leading tobacco control researchers, is now echoing the line being taken by Chapman and others that plain packaging should not be seen as a stand-alone policy in itself: 'Despite the expected benefits of plain packaging, it is important to remember that it will be most effective as part of a comprehensive tobacco control strategy that includes other policies, such as access to stop-smoking services, restrictions on sales to young people and effective taxation.'

If Chapman and Maynard are right, we may never know what impact the policy has had over and above the other tobacco control measures that have been robustly adopted in Australia. Not knowing whether it has actually reduced smoker numbers will not satisfy countries that are considering whether they too should follow the Australian government in implementing a similar policy.

> 'Plain packaging might well function as a "slow burn", distal negative factor against smoking.'

Neil McKeganey is director of the Centre for Drug Misuse Research, Glasgow

MEDIA SAVVY

The news, and the skews, in the national media


NEWS
LIBERAL MIDDLE CLASSES ARE IDIOTS SHOCKER

BUYING ETHICALLY PRODUCED FOOD, and making a statement about yourself by doing so, is now so easy it requires little or no thought. Thinking about where your narcotics come from, on the other hand, is so difficult it's simply easier not to do so... We are, it seems, living in the age of the wonky moral compass: of middle-class couples who swear by their weekly organic veg box, and yet relax after dinner with a line of something produced by impoverished, subjugated Bolivian peasants.
Jay Rayner, *Guardian*, 19 August

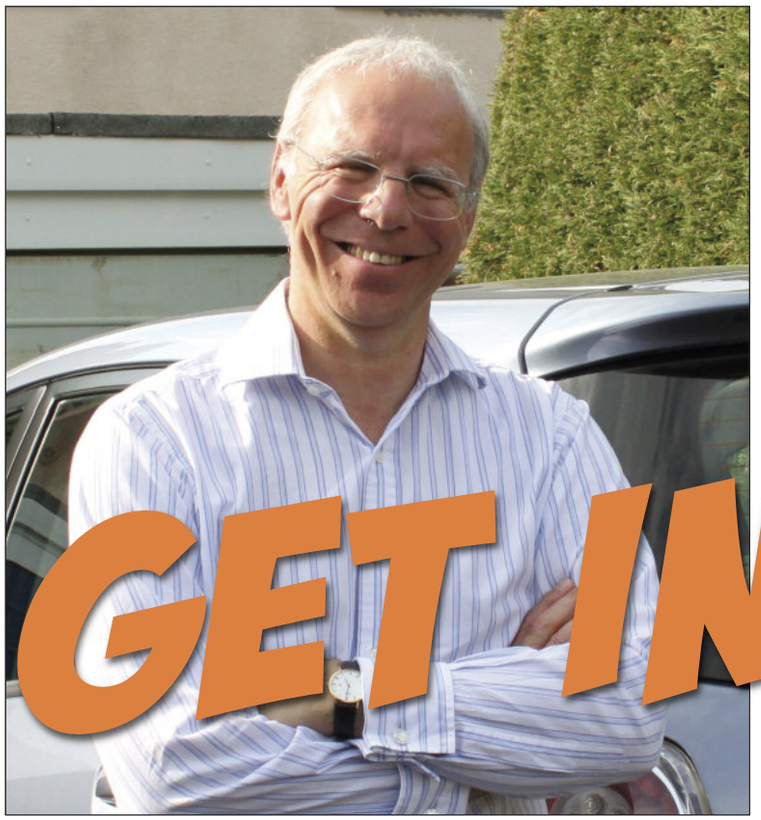
CREATING A FUG OF CONFUSION, Public Health England suggests e-cigarettes should be dished out by the NHS, while the Welsh Government says they should be banned in enclosed public places. The *Mail* believes both are wrong... In different ways, both Public Health England and Labour-run Wales are behaving like nannies. How about treating the public like grown-ups?
***Mail* editorial, 20 August**

THE 'PUBLIC HEALTH' LOBBY is a lumbering beast that goes from one extreme to another. If it is not trying to ban something, it is trying to subsidise it. What e-cigarettes and their users really need is to be left alone.
Christopher Snowdon, *Telegraph*, 19 August

TOBACCO is the largest single cause of preventable deaths in England – e-cigarettes may have a part to play to curb tobacco use. But the reliance by PHE on work that the authors themselves accept is methodologically weak, and which is made all the more perilous by the declared conflicts of interest surrounding its funding, raises serious questions not only about the conclusions of the PHE report, but also about the quality of the agency's peer review process. PHE claims that it protects and improves the nation's health and wellbeing. To do so, it needs to rely on the highest quality evidence. On this occasion, it has fallen short of its mission.
***Lancet* editorial, 29 August**

OUR DESCENDANTS WILL WONDER if we were ourselves drugged as well as unhinged when, in future times, they mourn and regret our irreversible folly in legalising this dreadful poison [cannabis]. Haven't alcohol and tobacco done enough damage, and made enough profit for cruel and greedy people?
Peter Hitchens, *Mail on Sunday*, 23 August

AS SOMEONE WHO CHOOSES to not drink, I have become acutely aware of how alcocentric the UK is, and how drinking is consistently tied in with having fun and being happy and relaxed. The predominant message is that alcohol is a prerequisite for letting your hair down and living it up.
Lucy Rocca, *Guardian*, 12 August



GET IN GEAR

David Finney guides you through the new CQC inspections

The Care Quality Commission has just published guidance on the new way in which treatment services will be inspected. The process will be very different from before, because the inspections are now organised by the Hospital Directorate.

THE FIRST MAJOR CHANGE is the introduction of a 'briefing and planning session' with an inspector at the outset of the inspection process. This will be an opportunity for you to explain how your service works, and will enable the inspector to plan the site visit appropriately.

At this stage you will also be asked for contact information for your stakeholders, who will be surveyed by CQC. These will include commissioners, local authorities, referrers from drug and alcohol teams, doctors, social workers and care managers.

THEN AN 'INTELLIGENT MONITORING' PHASE WILL START, during which CQC will gather data. Some of this will be provided by you, such as:

- *Outcome data, eg on completion or return to treatment, abstinence rates, safeguarding alerts.*
- *Information from service users and the public (usually obtained through surveys).*
- *Information from and about staff, eg turnover, stability, sickness rates and concerns raised.*

FURTHERMORE, you will be asked questions in a 'provider information return', which will include specific questions about:

- *Safety and effectiveness, including serious incidents, DoLS (Deprivation of Liberty Safeguards) or medication errors.*
- *Complaints and how governance is exercised (do you learn from incidents and mistakes?)*
- *Equality and diversity, ie examples of how it is evidenced, or data to show that specific groups are not discriminated against.*
- *How improvements are made in the service.*

ANOTHER MAJOR CHANGE IS THAT YOU WILL BE GIVEN A DATE FOR A SITE VISIT and CQC will seek information about your service in the intervening period. This will give you an opportunity to audit your service thoroughly before the site visit takes place.

At the beginning of the visit, there will be an opportunity for you to give a 'provider presentation', in which you can:

- *Outline the background to your organisation. I suggest that you include an explanation of your treatment philosophy.*
- *Show that you provide quality care. Demonstrating an understanding of the five key questions (safe, effective, caring, responsive and well led) will be helpful.*
- *Demonstrate what is working well or is outstanding. You could focus the success rate in terms of completions and the compliments you have received.*
- *Highlight any areas of concern or risk. For example, you could mention any boundary issues such as transition, or any issues you may have with mental health teams.*

THEN, DURING THE VISIT, THE INSPECTION TEAM WILL observe interactions between staff and service users, talk with service users, staff and the manager, and look at some records.

There are actually very few questions in the methodology that are specific to substance misuse treatment. However, those that are include:

- *Identification of drug and alcohol-related harm, and deteriorating health.*
- *An opportunity to explain the restrictions on movement usually imposed as part of a treatment programme.*
- *The involvement of recovery champions.*
- *Processes in place for unexplained or unplanned discharges.*
- *The planning of services to take account of people with complex needs or vulnerabilities – such as dual diagnosis, multiple drug use, homelessness, pregnancy, or criminal justice involvement.*

FINALLY, IT HAS NOW BEEN DECIDED THAT CQC WILL NOT BE ABLE TO GIVE 'RATINGS' FOR SUBSTANCE MISUSE TREATMENT SERVICES. This is because they were not included in the list of services given to the Department of Health when drafting the regulations, so CQC has no legal power to provide ratings. This decision applies to everyone in the sector, so no specific group of services will be disadvantaged by it.

The full information about the new inspection process can be accessed at www.cqc.org.uk/content/guidance-providers. I wish you the very best of success in navigating this new system and will continue to update you through *DDN* as and when new information becomes available.

David Finney is an independent social care consultant. His workshop is on 6 October in London, details at www.drinkanddrugsnews.com

Date: Thursday 5 and Friday 6 November
Venue: The Park Inn, York, UK

SSA SOCIETY FOR THE STUDY OF ADDICTION

Annual Symposium, 2015

Themes: Cannabis: new research | Take-home naloxone and the potential to prevent overdose | Recent findings from ARUK-funded research | Recovery | Science & Politics – Synergy or conflict?

Professor Thomas McLellan will give the Society Lecture:
'Recovery' or 'Disease Control' is an expectable result of comprehensive, continuing addiction treatment

Speakers & presentations:

Duncan Raistrick • *Measuring recovery*
Sheila Bird • *Naloxone on prison-release saves lives in Scotland, but why not elsewhere?*
Lucy Rocca • *The barriers that prevented me from addressing my alcohol dependency for twenty years - And how* ***Soberistas.com*** *seeks to address these*
Paul Morrison • *Cannabis and mental health*
Thomas Clausen • *New trial of naloxone nasal spray in Norway*
Annette Dale Perera • *The drive to time-limit OST – Is it austerity or ideology? Is it good science and good practice?*
Val Curran • *Cannabis: Pleasure, medicine and mental health*
Hannah Rose • *Adolescent alcohol beverage preferences and related harms: A latent class analysis*
Jo Neale • *Experiences of naloxone resuscitation – Qualitative exploration*
Colin Drummond • *Minimum unit pricing for alcohol*
Amanda Atkinson • *The role of social networking sites in young people's drinking cultures*
Helen Crosby • *Rating therapist competence*
John Strang • *Findings from application of the Bradford-Hill criteria*
Judith Harwin • *The Family Drug & Alcohol Court*
Andrew McAuley • *National co-ordination and provision of take-home naloxone: Scotland first*
Laura Willoughby • *Club Soda - Behaviour change and social action*
Niamh Fingleton • *Non-prescription medicine dependence in the UK*
Ann McNeill • *Plain packaging of cigarette packs to reduce consumption*
Deborah Arnott • *The e-cigarette: Opportunity or threat?*
Felix Naughton • *Q Sense: A context aware smartphone sensing app for smoking cessation*
Harry Sumnall • *The alcohol harm paradox*
Rebecca McDonald • *How strong is the evidence for benefit from take-home naloxone?*
Jan Gill & Jonathan Chick • *Alcohol pricing and heavy drinkers in Scotland*

Book your place online:
Discounts available for early-bird booking, members, student-associates and unwaged delegates
www.addiction-ssa.org/symposium

Join the Society as a member or a student associate:
www.addiction-ssa.org/membership

Submit your abstract for oral or poster presentation:
Any addictions subject considered. 3 x £250 prizes to be won! Deadlines: 11 September/9 October
www.addiction-ssa.org/symposium/abstract

Accommodation
Preferential rate rooms in the conference hotel: **www.parkinn.co.uk/hotel-york (+44 1904 459 988)**
York tourism office: **www.visityork.org/book**

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Employment Education Recovery Mental Health Drugs Peer Support Health Care in the Crime Family Housing Addiction Alcohol Community Conference 2015

THIS YEAR'S THEME

EVOLUTION OR REVOLUTION

BOOK NOW!

Are we entering an 'all change' recovery revolution driven by passionate rebels or is recovery simply an evolution in long-established addiction practices?

Join us in our new venue of the world-famous Crucible Theatre on 9th November in Sheffield.

HIGHLIGHTS INCLUDE:

The Change Makers those who are passionate about recovery but have the courage to do things differently.

Recovery Room 101 Innovative and provocative! Hear from a panel of opinion formers, leaders and rebels, who could revolutionise addiction support as we know it.

Recovery Gone Global Hosted by Professor David Best and our conference partner Sheffield Hallam University, we'll be comparing international survey findings to see whether recovery is evolving on a global scale.

Sheffield Hallam University

Also Musician Adam Norrie; Soberista's Lucy Rocca; short and snappy Recovery Talks.
AND a new venue to boot!

www.recoveryinthecommunity.org.uk

LETTERS AND COMMENT

GAME CHANGER

I was brought up in the care system due to my mother committing suicide. Mum was an addict and dad was an alcoholic, so my childhood was pretty messy. By the time I was 13 years old, I had lived with ten different foster carers, including two kids' homes.

I was running from the pain of my past, hurting others and myself. I was a heavy drug user and always in trouble with the police. I have lived in prison for two years and make no excuses for my crime – however I do believe there is a strong link between crime, addiction and mental health. Before coming to prison I tried so hard to get help, but my funding to rehabilitation was blocked because I was unstable.

While living in prison I have been shocked at the lack of interventions to cure people of crime and drugs. It is too focused on punishment, rather than using the time for great work. More than 70 per cent of people in prison have addiction issues and many suffer mental health problems.

The government drug strategy sets out ambition to tackle substance abuse by building recovery communities within prisons and beyond, but I am saddened at the lack of recovery groups, which could seriously reduce the reoffending rate. Is it really so difficult to start some serious joint working? It breaks my heart to think of men locked in a cell 23 hours a day when we could be using this time to help them – not to mention the annual £40,000 cost to the taxpayer.

> 'Askham Grange is the prison that has changed my thinking and behaviour because staff encourage you to believe you can be a constructive member of society. It has a six per cent reoffending rate compared to the national 60 per cent.'

Askham Grange is the prison that has changed my thinking and behaviour because staff encourage you to believe you can be a constructive member of society. It has a six per cent reoffending rate compared to the national 60 per cent and was awarded 'outstanding' by Ofsted twice within two years. Our prisons should be places where people recover, rehabilitate and move away from crime. The staff here make us realise teamwork is essential in keeping our environment friendly, safe and secure. I feel I now have a future away from crime, drugs and poverty.

The prison has a project called 'Me, No Way', where prisoners talk to kids in schools – an emotional experience that really makes you feel part of our community.

We also have a mother and baby unit and the gym courses are excellent – an opportunity that also steers people away from crime and drug-fuelled hostels.

I now have a university degree and would like to develop a social enterprise that employs ex-offenders. Askham Grange has made me believe I am a winner, not a loser, and that I can help others. On behalf of all prisoners, I would like to thank the staff here for seeing us as human beings who have the power to change and become better people.

I hope this letter reaches the eyes of those who have the power to change things. Politicians and commissioners could learn so much from the long-term benefits of Askham Grange.

Paula Wainwright, HMP Askham Grange

WHERE'S THE LOGIC?

I've just been reading the latest in a long line of letters by Ken Eckersley, CEO of Addiction Recovery Training. In the recent letter (*DDN*, July/August, page 9) he is onside with Neil McKeganey, calling for 'regular' and 'exhaustive' drug-testing in UK prisons.

Having worked with class A drug using offenders for over five years it's clear that something is wrong in our prison system, but I staunchly believe more prohibitive measures are not the answer.

Where does it begin and where does it end? Do you propose testing for every single drug? Because, in my experience, if folk want to use, addict or not, they will find a way. One only has to look at the extensive list of illicit prescription drugs that are currently being used and abused. Or are we to outlaw the use of every pharmaceutical drug too? Prohibition is not a deterrent and I don't believe it ever truly will be.

It's a cliché, but change comes from within. Good people can be around that person before they are ready – and good people can be around them when it's time to help realise that change, but no amount of therapeutic coercion or 'immediate transfer' will support that change. I have never heard of demoralisation and lack of autonomy being supportive factors in people's recovery.

Another thing to note is that when mandatory testing for cannabis was introduced, the fallout was such that many inmates who had never used anything but cannabis in jail turned to heroin, as it left their system quicker. What happened next was they left prison with a heroin habit to feed and, for many, this began the 'revolving door' of years in and out of prison. So I fail to see how the proposals are either 'effective' or 'logical'.

Ken ends his letter on a real bum note when he cites China and the US as countries to look to; China with human rights violations galore and the latter being the proud offender of incarcerating more people than anywhere else in the world, many of whom are serving time for non-violent drug offences, with some on life without parole for possession.

For an alternative DVD recommendation please watch *The House I Live In* and check the logic.

Support don't punish!

Jesse Fayle, student mental health nurse and former criminal justice recovery practitioner/DIP worker

KHAT QUESTION

What has been the outcome of the UK government's khat ban? This is an example of the sort of research question that home secretaries like Theresa May are typically uninterested in, and which is therefore far less likely to receive public funding.

By contrast, successive governments encouraged reports that aimed to demonstrate that khat chewing was dangerous and should be banned. When the reports

DDN WELCOMES YOUR LETTERS

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

Get involved:
www.drinkanddrugsnews.com

'...has khat dependence among the affected adults declined? Or have people just switched to illicit khat, or alternative stimulants that increase harm? '

concluded that a ban wasn't necessary, they waited a bit then commissioned another report. In the end, khat was banned irrespective of research that was ambiguous about the harms at best.

But if the harms were so serious that culturally embedded traditions of British Somalis and Yemenis should be criminalised, it seems equally important to find out whether the policy has been effective and whether these harms have now been reduced. Not to do so might even be construed as a racist oppression of these minorities by the British state.

For example, has khat dependence among the affected adults declined? Or have people just switched to illicit khat, or alternative stimulants that increase harm? Has there been a decline in community cohesion (because khat chewing is traditionally a social activity; not unlike going to the pub for many other British people)? How does the ban mediate the drug-taking careers of second generation Yemeni and Somali youth *ie* was khat chewing protective against the use of other widely available illicit drugs, or did it provide a gateway to more problematic drug taking?

I have no expectation that these questions will ever be deemed worthy of the sort of public funding considered necessary before khat was banned. But I think they are interesting to highlight, because of the way they add to the evidence that knowledge production is biased towards answers that serve a specific agenda. Bias that – in this case – can contribute to forms of cultural oppression, which might even be relevant to broader narratives on the production of terror.

Neil Hunt, Kent

FALSE RESULTS

I see that you reported the drug-driving figures from the Institute of Advanced Motorists (IAM) as have other publications (*DDN*, July/August, page 4). They give the numbers arrested, not charged, and not the number found guilty or not guilty.

At this stage if they have tested presumed positive roadside, they would have a further test to confirm the result.

Are these figures available? They should be – after all, some would have been arrested and put through the courts in March.

My concern is that the initial tests are prone to false results, and in this case it would be false positives. (You will never know of the false negatives!)

David Mackenzie, by email

CORRECTION

Last issue's article 'Hidden Menace' (*DDN*, July/August, page 6) contained reference to the book *Pure, White and Deadly*. The author of this work is John Yudkin (not Rudkin) and we apologise for this error.

LET'S CONNECT!

HAVE YOUR SAY BY COMMENTING ON OUR WEBSITE, FACEBOOK PAGE AND TWEETING US

BEN GUNN
@prisonerben1 *29 Jul 2015*
The first step in #prison reform is to ask ourselves who we send to prison, and why.

INSIDE TIME
@InsideTimeUK *24 Jul 2015*
@DDNMagazine What is vaping? Seems like an adult dummy disguised as a cigarette.

BELINDA LANGLEY
@lankelangley *12 Aug 2015*
@DDNMagazine while I have no disagreement with smoking, if I can be fined for drinking pop at a red light by jobsworth PCplod, then smoking...

BELINDA LANGLEY
@lankelangley *12 Aug 2015*
@DDNMagazine ...should also not be allowed while in a car, more so when in motion! Definitely not while a child is in the car!

GAVIN BENN
@HL_GavinBenn *14 Aug 2015*
#Naloxone regs changing Oct15 affecting all #homelessness services. [http://drinkanddrugsnews.com/naloxone-distribution/] shows #Birmingham leading the way @DDNMagazine

HUGH JARSE
@Pablo1963 *19 Aug 2015*
@DDNMagazine They don't quit, they just substitute. I fully expect that in 20 years time we'll find out that ecigs cause terminal illness

SEBASTIEN ALEXANDRE
@seb_alexandre *21 Aug 2015*
@DDNMagazine An effective global drug policy could finally reach reasonable public health objectives. The War on Drugs never did @feditobxl

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www.drinkanddrugsnews.com

FIND OUT WHAT'S GOING ON IN YOUR AREA ON

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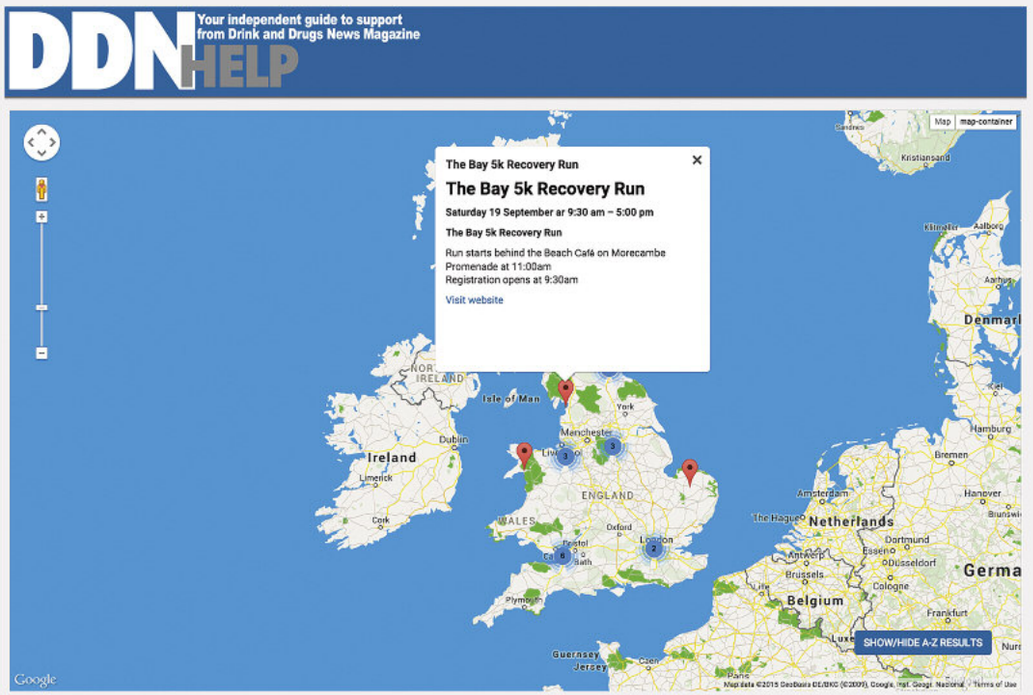

Whether you want to walk, run, ride your bike or throw some shapes, there's something for you this recovery month!

Throughout September there are events the length and breadth of the country celebrating the power of recovery.

DDN Help is a free resource to help you find everything you need relating to addiction – from treatment and training to events and job opportunities. Just search the map and you'll find a handy listing of what's happening near you.

Visit www.ddnhelp.com for more information, and don't forget to drop the DDN team a line to let us know how you celebrated recovery this September – email kayleigh@cjwellings.com.

A DECADE OF DDN

In September 2005 the Alliance's development manager, Daren Garratt, asked why we still tolerate discriminatory legislation

The importance of integrating drug user involvement and peer-led support with drug treatment within the criminal justice system can't be underestimated, but there remains a very real fear that, unless we can lobby for effective policy change at a strategic level, we may be dooming many ex-cons to fail; particularly those who view user involvement as a way to mobilise themselves, secure employment and give something back to their community.

Why? Because under present legislature you cannot get public liability insurance if you've got a conviction, regardless of the nature of the crime or when you served your sentence. It's a shameful situation that makes a mockery of the Rehabilitation of Offenders Act, and could seriously jeopardise both the NTA's treatment effectiveness strategy and the Home Office's new peer support project.

Think about it. You've just completed a prison sentence and, thanks to the highly effective, individually tailored drug treatment regime you received, you're ready to contact your DAT, get involved in user involvement and, ideally, set up your own group and provide some peer-led interventions. The DAT is great, the local agency is encouraging and gets you in touch with some local users and neighbouring groups who willingly share their best practice and help you draw up a terms of reference and constitution.

You're all set. This is the last step in your recovery. You've found your vocation, you're respected, you've got a purpose, self-worth and the ability to finally stop being defined by the mistakes of your past and build a brighter future. To celebrate, you decide to launch your new group with a big DAT-supported open-air event... but you can't because you can't get public liability insurance, which also means you can't legitimately establish your group and support your peers in your own premises. You're back to square one. What was the point?

DDN back issues are available to search and read online at www.drinkanddrugsnews.com

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- *24 hour care*
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- *Pre admission assessment required*
- *Holistic approach*
- *Structured day care program*
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11.30am-4pm

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Please confirm your attendance one week before the event to Caroline Bazin

caroline.bazin@phoenix-futures.org.uk/ phone: 01489 872 816/ fax: 01489 877 555

www.phoenix-futures.org.uk

*this is a free event, lunch and refreshments are provided

The Impact of Alcohol on Health and Society

17th November 2015

Glaziers Hall, London – Just £99

Alcohol Concern's Annual Conference, 'The impact of alcohol on health and society', will be this year's key event for everyone with a professional interest in alcohol issues, from local authorities to the police, from public health professionals to those who work in the social care system.

Delegates will have the chance to hear from leading experts on a broad range of topics including the impact of alcohol on emergency services, lessons from the Scottish Government, alcohol and mental health, forthcoming guidelines on alcohol and the latest research on alcohol and cancer. There will also be a chance to participate in workshops, network with peers from different sectors and meet our exhibitors.

Click here for booking details and an agenda

www.alcoholconcern.org.uk

For more information , please contact Charlene on corr@alcoholconcern.org.uk or 020 7566 9800

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DDN/FDAP WORKSHOPS

We are pleased to offer the following workshop:

TUESDAY 6 OCTOBER, LONDON

CQC compliance workshop

STAY AHEAD OF THE LATEST CQC CHANGES!

CQC have just released guidance on the new way that treatment services will be inspected – make sure you're prepared.

During this workshop, you'll hear how to get your organisation ready for an inspection, and what the focus of your preparations should be.

The workshop will be delivered by **David Finney**, an independent social care consultant and author of the *National guidance for inspectors of residential services* for people recovering from drug or alcohol addiction, and **Carole Sharma**, Chief Executive of the Federation of Drug & Alcohol Professionals.

The course will take place at Asra House, 1 Long Lane London SE1 4PG. Coffee and registration is from 10am, and refreshments will be provided throughout the day. Training finishes at 4pm.

***£145 per person** (15% discount for FDAP members), includes lunch and refreshments.*

Full details and online booking

www.drinkanddrugsnews.com

Share your story in the RECOVERY STREET FILM FESTIVAL

Come along to September showings:
12th, Durham • 15th, Blyth
17th, Manchester • 19th, Glasgow
22nd, London • 26th, Sheffield

Full details on www.recoverystreetfilmfestival.co.uk

BRACKNELL FOREST DRUG & ALCOHOL ACTION TEAM ARE SEEKING TO COMMISSION DRUG & ALCOHOL RECOVERY SERVICES

Bracknell Forest Council

The Drug and Alcohol Recovery contract will be awarded on a Prime Provider Basis from 1st April 2016. The contract will be awarded for 3 years with the possibility of extension for 3 further years (3+1+1+1).

The Prime Provider will be responsible for delivering or sub-contracting a full range of recovery services which will include but are not limited to the following:

- *Brief interventions, advice, peer support programmes*
- *Structured programmes of care to include Drug Rehabilitation Requirements, Alcohol Treatment Requirements and Youth Restorative Orders*
- *Assertive outreach services, both community & criminal justice*
- *Parenting programmes*
- *Substitute Prescribing (including Dual Diagnosis)*
- *Alternative Therapies*
- *Awareness training to improve early interventions*

The service will be provided to adults and young people who reside within the boundaries of Bracknell Forest Council. Payments for the services delivered will be made on a Payment by Results approach for any individual entering treatment after the contract start date. A set contract value will be applied to any person already in treatment on the transfer date which will be paid over the first year in 12 equal installments. In addition to this, there will be a small outcome payment due in respect of successful completions for this cohort.

The contract value will be determined by the payment by results activity. The lower value is anticipated to be approximately £340,000, with a maximum value not exceeding £420,000.

For further information and to express an interest please go to the South East Business Portal ***https://www.businessportal.southeastiep.gov.uk*** *and search in Opportunities.*

The closing date for submission of completed Invitations to Tender is 12:00 noon on 6th October 2015.

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Next issue Monday 5 October
Print advert deadline 2 October

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