DRINK AND DRUGS NEWS ISSN 1755-6236 DECEMBER 2015

DDN

INSIDE

Shaping the 2016 drug strategy

2015 in review

PLAYING SAFE

ENSURING PROPER SAFEGUARDING FOR CHILDREN

Merry Christmas and a Happy New Year to all our readers

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9th DDN national service user involvement conference

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'Agencies must work together... what a difference they can make when engaged'

Talking about child safeguarding requires such a delicate balance. Why are we missing signs that children are at risk? The recent Adfam/DDN conference (page 10) highlights 'one of the most difficult and fraught areas of practice', 'a Pandora's Box', that finds us wanting in 'honesty and courage as a sector'. How can we redress this?

Adfam's research finds training to be crucial, as well as agencies working more effectively together to minimise risk – a point illustrated by Karen Hammond, speaking at the *HIT Hot Topics* conference about the (potentially pivotal) role of public health nurses. What a difference they can make, when properly informed and engaged.

I don't need to remind you that it's been a tough year (page 18). Gathering thoughts on where we should head for a new drug strategy, Paul Hayes wants to build on the vision of keeping the individual at the centre of treatment. But for some, this is already a far cry from reality, as diamorphine prescribing is driven from the treatment landscape (page 6). Who cares about the evidence base now, asks Erin O'Mara.

We need to hear about your experience of treatment in time for the ninth national service user involvement conference in February. Our theme is 'Get the picture' and we want your experiences – please head to our website to get involved. While you're there, don't forget to renew your free subscription if you want to keep receiving DDN!

I hope there's plenty in this issue to keep you in touch with us over the break – we'll be back with our next issue on 1 February. In the meantime, have a happy and restful Christmas and new year.

Claire Brown, editor

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IRELAND CONSIDERS CONSUMPTION ROOMS AND DECRIMINALISATION FOR PERSONAL USE

THE GOVERNMENT OF IRELAND is considering the introduction of drug consumption rooms, as well as decriminalising small amounts of drugs for personal use.

The announcement was made as part of a speech by new communities, culture and equality minister Aodhán Ó Ríordáin, who has responsibility for the country's national drugs strategy, to the London School of Economics IDEAS Forum.

Consumption rooms had proven effective in engaging hard-to-reach populations, said Ó Ríordáin, and he had asked officials to examine 'proposals for the provision of medically supervised injection facilities' in line with European and Australian models. This was partly to address problems with street injecting in Dublin and elsewhere, as well as a recent spike in blood-borne viruses, he said, telling the *Irish Times* newspaper that the facilities would 'happen next year'. The country's health minister Leo Varadkar, however, has stressed that while he supported the proposal it would require a change in the law and would not be 'a simple matter'.

A drugs policy review has also been launched to consider whether a decriminalisation approach to the possession of 'small quantities' of drugs – such as currently operates in Portugal – should be considered in Ireland, although there was 'certainly no desire for a permissive approach to drugs', Ó Ríordáin emphasised.

While the country's drug strategy was one that was 'firmly focused on recovery', a changing drugs landscape required renewed focus and innovation, he stated. 'I am in favour of a decriminalisation model, but it must be one that suits the Irish context and be evidence based. I believe that this kind of approach will only work if it is accompanied by timely treatment and harm reduction services, backed up by wrap-around supports which foster recovery – such as housing, health and social care. Above all, the model must be person-centred and involve an integrated approach to treatment and rehabilitation based on a continuum of care with clearly defined referral pathways.' *Full speech at www.merrionstreet.ie*

Pic: Neil Ward

'I am in favour of a decriminalisation model, but it must be one that suits the Irish context and be evidence based.'

AODHÁN Ó RÍORDÁIN

HEP UNAWARENESS

Almost half of injecting drug users are unaware of having hepatitis C, according to PHE figures. Despite uptake of testing standing at more than 80 per cent of users, around 48 per cent of infections were undiagnosed, says the latest *Shooting up* report. Regular testing – whether through treatment services or primary care – remains 'crucial' to protecting health, says PHE. Meanwhile, the World Hepatitis Alliance has stressed that the faster progression of viral hepatitis in HIV patients means this group is three times more likely to suffer liver disease, liver failure or liver-related deaths. The organisation is calling for more recognition of hepatitis and HIV co-infections. *Shooting up: infections among people who inject drugs in the UK, 2014 – an update at www.gov.uk*

'NO EVIDENCE' MEANS IRRESPONSIBLE DEAL

The government's public health responsibility deal for alcohol has pursued initiatives 'known to have limited efficacy' while obstructing more meaningful action, according to a report by the Institute of Alcohol Studies (IAS). 'With no support from the health community, and no evidence of effectiveness, it would be absurd for this government to continue with such a farcical initiative,' said IAS director Katherine Brown. *Dead on arrival? Evaluating the public health responsibility deal for alcohol at www.ias.org.uk*

BRIEF BRIEFING

'Decisive' coordinated action is needed to ensure a future for alcohol brief interventions, according to a report from the Alcohol Academy and Alcohol Research UK. Alcohol identification and brief advice (IBA) has proved difficult to implement effectively, says the document, with ongoing issues around primary care as the key setting and 'understanding what brief intervention actually involves'. *Alcohol brief intervention: where next for IBA? at alcoholresearchuk.org*

SEIZURE STATS

The number of drug seizures in England and Wales fell by 14 per cent in 2014-15 to just over 167,000, according to figures from the Home Office. More than 124,000 of these were seizures of cannabis – down by 17 per cent on the previous year. Overall class A seizures were also down by 10 per cent, despite seizures of heroin increasing by more than 70 per cent. *Seizures of drugs in England and Wales, 2014/15 at www.gov.uk*

HELP IN SIGHT

The first guide to substance use and sight loss has been published by the Thomas Pocklington Trust, and includes key resources for professionals and best practice examples. 'Our research found that both sight loss and substance abuse services are not adequately equipped to deal with these overlapping issues,' said lead author Sarah Galvani. 'Substance abuse can sometimes be used as a coping mechanism for sight loss, but the combination of both issues can create a complex challenge for support professionals.' *Substance use and sight loss at alcoholresearchuk.org*

SAFEGUARDING ACTION

MORE CHILDREN than previously thought are dying or being hospitalised after ingesting opioid substitution therapy (OST) medications, according to a new report from Adfam. The charity says lessons from previous tragic cases have still not been learned and wants to see all incidents of children ingesting OST medication 'fully investigated and recorded', with the information properly analysed and shared with local services. Adfam is calling for proper training for parents as well as for all professionals who come into contact with parents and carers prescribed OST drugs.

Medications in drug treatment: tackling the risks to children – one year on at www.adfam.org.uk

See feature, page 12

Lessons from previous tragic cases have still not been learned.

HELPING CHILDREN TALK ABOUT PARENTS' TREATMENT

A NEW RESOURCE BOOKLET has been produced by The Children's Society to help young people affected by a parent or carer's alcohol or drug treatment.

Help me understand aims to encourage ten to 14-year-olds to talk to support workers and has been designed to communicate simply and directly, including messages from others in the same situation.

'While having a parent or carer in treatment can be a positive thing, it can also be very confusing and distressing,' said Joanna Manning, national lead on substance misuse at The Children's Society. '[This] will be a valuable tool for workers to use in helping children and young people to stay safe and to understand the importance of accepting and sharing their feelings.'

The booklet was launched at Adfam/*DDN*'s safeguarding conference *Everybody's business*, held in Birmingham.

Available to download at www.starsnationalinitiative.org.uk

Jason Flemyng was among those at the event to speak about the effects of addiction, having seen his father struggle with alcohol.

'LOCK, STOCK' STAR GIVES BOOST TO RAPT DAY PROGRAMMES

JASON FLEMYNG, star of *Lock, Stock and Two Smoking Barrels*, lent his support to Alcohol Awareness Week (16-22 November) with a visit to two of RAPt's London community programmes – the Tower Hamlets Community Alcohol Team (THCAT) and the Island Day Programme.

He was among those at the event to speak about the effects of addiction, having seen his father struggle with alcohol.

'I am only too aware of the stigma around it,' he said. 'These projects are brilliant – not only because of the incredible transformation it can help bring for those struggling with drink or drugs, but because of the support and understanding there is for families too.'

DRINKAWARE PILOT KEEPS CLUBBERS STREETWISE

YOUNG CLUBBERS in the south west will be targeted through the Drinkaware Club, a six-month pilot by the alcohol education charity.

Joining forces with local police, community partnerships and police and crime commissioners (PCCs), Drinkaware has trained staff in bars and clubs to increase safety by reducing drunken anti-social behaviour. Working in pairs, club hosts will begin by talking to customers as the queue is forming and ensure they leave safely as the venue closes.

'I am delighted at the level of engagement and support we have had from local partners,' said PCC for Devon and Cornwall, Tony Hogg. 'We have been working closely with local authorities, street pastors and the venues to put this pilot together.'

AWARDS RECOGNISE STERLING EFFORT IN TACKLING STIGMA

THE FIRST MARSH RECOVERY AWARDS have been presented at Addaction's recovery conference in Manchester – a result of the charity's partnership with the Marsh Christian Trust.

Chosen for their outstanding contributions to raising awareness and reducing stigma in the field of recovery, the winners were: Kerrie Hudson for 'exceptional individual'; Club Soda for 'exceptional activity'; peer supporters at RISE in Devon for 'exceptional group'; Max Daly, author of the *Narcomania* column in *Vice* and Sarah Hepola, author of *Blackout: Remembering the things I drank to forget,* for 'exceptional media'.

TREAT YOURSELF AT ONLINE AUCTION

BROADWAY LODGE has launched an online auction to raise funds for treatment. To be in with a chance of winning two full-hospitality tickets for a day at the races, framed shirts from football stars, Sunday lunch at the Doubletree Hilton, a laptop and many more prizes, visit www.broadwaylodge.org.uk.

DYFRIG HOUSE OPENS NEW DOORS TO HELP CARDIFF'S HOMELESS

A SPECIALIST ACCOMMODATION and support centre has been set up at Dyfrig House in Cardiff to help homeless people with alcohol or substance misuse problems.

The 21 self-contained bedrooms... will support residents towards independent living.

The 21 self-contained bedrooms with private ensuite toilet and shower facilities, will support residents towards independent living and have been described as 'not a hostel [but] therapy' by one resident.

Since opening in 1967, Dyfrig House has provided one of the few 'dry' homeless services in the city. The completely refurbished service – result of a partnership between Solas (which provides accommodation for homeless people), Cardiff City Council and the Welsh Government – offers an individually tailored therapeutic support model.

Lee Sutcliffe, who feels he owes his life to Dyfrig House, said: 'I was made to feel safe straightaway, which I hadn't felt in a very long time... it's a very, very special place indeed.'

WELCOME EVENTS PROVE POPULAR AT FORWARD LEEDS

A SERIES OF OPEN MORNINGS across the city have proved a successful venture for alcohol and drug charity Forward Leeds.

The Wednesday morning events have introduced service users, local residents and businesses the facilities and given them the chance to meet staff, ask questions and learn about what goes on at the charity, including the needle exchange and other harm reduction activities.

The service's executive director, Lisa Parker, said they were extremely pleased at the turnout at the events and added, 'The events have also been an opportunity for us to recognise the hard work our staff do... we made sure each staff member got a Forward Leeds purple and pink cupcake.'

'The events have also been an opportunity for us to recognise the hard work our staff do...'

LISA PARKER

THE STATE

Forcing stable people off their heroin scripts and into chaos is evidence of a British drug treatment system in terminal decline, says Erin O'Mara

The game of history is usually played by the best and the worst over the heads of the majority in the middle.
Eric Hoffer

'I feel like they are waiting for the last handful of us to die off and that will be the end of heroin prescribing in Britain, as we know it', I said miserably.

Gary Sutton, Release's head of drugs services, turned and looked at me seriously through his spectacles: 'If we don't try and do something now there will be no diamorphine prescribing left anywhere in the UK.'

Gary tapped away on the computer in front of me, putting the last few lines on a letter to yet another treatment service who had been forcibly extracting a long-term client off his diamorphine ampoules and onto an oral medication. It was proving to be a painful and destructive decision for the client, who was experiencing a new daily torment as his once stable life began to unravel around him.

The drug team and its helpline (known affectionately as 'Narco'), all part of the UK charity Release, receives phone calls from people in drug treatment from all over the UK. By doing so it serves as the proverbial stethoscope clamped to the arrhythmic heart of our nation's drug politik and bears witness to the fallout from Number 10 affecting the individual, on the street and in treatment. In other words, we witness the consequences of policy and treatment decisions, and try to support or advocate for the caller.

But as winter draws the shades on yet another year in the drugs field, we find we are bearing witness to a tragedy, one of small proportions but with huge implications. It involves the last vestiges of the British system of drug treatment, the 'jewel in its crown' – heroin prescribing – and the decline of the NHS, under assault from a mercilessly competitive tendering process and the crude procurement that is defining its replacement. Is that where we are really heading?

'If we don't try and do something now there will be no diamorphine prescribing left anywhere in the UK.'
GARY SUTTON

It may be true to say that to try to define the old 'British system' is to trap its wings under a microscope and allow for a possibly contentious dissection; the late 'Bing' Spear, formerly chief inspector of the Home Office drugs branch, might be first in line by reminding us that the implications of "'system" and "programme" suggests a coordination, order and an element of (state) planning and direction, all totally alien to the fundamental ethos of the British approach, which is to allow doctors to practise medicine with minimal bureaucratic interference'. His point being that the essence of the 'British

WE'RE IN

system' was that it 'allows the individual doctor total clinical freedom to decide how to treat an addict patient'.

John Strang and Michael Gossop, in their thoroughly researched double volume book *Heroin Addiction and the British System*, stated in the epilogue of volume two, that 'amongst the (probably unintended) benefits of [this] approach may be the avoidance of the pursuit of extreme solutions and hence an ability to tolerate imperfection, alongside a greater freedom, and hence a particular capacity for evolution.'

The British 'approach' (as may arguably be a more appropriate phrase to use) had once allowed for a level of evolution; of experimentation and pharmaceutical flexibility; three characteristics that are glaringly missing from frontline drug treatment today. Although we have no room to discuss clinical guidance here, it is often the case that when presenting services with complex individual cases at Release, we are rebuffed by the response 'it's not in the guidelines', 'it's not licensed', or even, as if drug workers are loyal party backbenchers, 'it's not government policy'!

Hindsight is a gift, and although many of us could while away the hours pontificating about just how and why it all went so publically wrong for our 'unhindered prescribers' back in the day (think Drs Petro, (Lady) Frankau, and a handful of others), that would be to miss the point. The reality is, once we pick up and examine the pieces of the last 100 years, there are shining areas of light in our British approach. Marked by both a simple humanity and a brilliant audacity, it permitted a private and dignified discussion between doctor and patient to find the drug that created the preconditions for the 'patient' (today the 'client') to find the necessary balance in life.

Are we really back to the days of having to ask to be treated as an individual? Policy is now interfering in treatment to such an extent that the formulation that the patient feels works best for them (physeptone tablets, heroin, morphine, oxycodone, DF118s ***etc***) may no longer fit into today's homogenous and fixated theme of methadone or buprenorphine, one part of a backwards step.

The days when heroin prescribing was defended as tenaciously as a doctor's right to prescribe unhindered are almost gone. Fear and public ignorance have forced us to collapse any new diamorphine prescribing into a tight wad of supervision, medicalisation and regulation while prohibition, politics and the soundbite media have meant that we have been doomed to discuss this subject under the umbrella of 'treating the most intractable, the most damaged, the treatment failures, the failures of treatment'.

'Why must a treatment that has proven to be the optimum for so many people be left until people had been forced to suffer through a series of personal disasters and treatment failures? Did this narrative help to diminish the intervention?'

Why must a treatment that has proven to be the optimum for so many people be left until people had been forced to suffer through a series of personal disasters and treatment failures? Did this narrative help to diminish the intervention?

The last few dozen people left on take home diamorphine prescriptions in the UK today seem to be stable, functioning, often working people who no longer have so much a 'drug problem' as a manageable drug dependence. This last group of diamorphine clients are remnants of the old system with, it appears, no new people taking their places once they leave. Today these are some of the very people who are now ringing the Release helpline to try to save their prescriptions altogether. They are frightened, most of them are in their fifties and had qualified for diamorphine many years ago because 'nothing else worked'; what now are they to do?

Diamorphine prescribing has been ensconced in a political and clinical debate about the expense and fears of an imaginary tsunami of diversion. Yet what of today's financial wastage? We have ways to deal with diversion, yet poor and frequent commissioning has a number of serious consequences, including a lack of continuity of care, a slide back to postcode variance and, not least, cost. An exercise to quantify the costs of tendering services more than ten years ago came up with a figure of £300,000 as the sum expended by all bidders and the commissioner, per tender – money that could be better spent, surely?

A few weeks ago the LSE put on a mini-symposium on diamorphine with a panel of international clinicians, academics and research experts. Everyone present agreed that prescribing diamorphine, albeit in a very controlled, supervised manner, had tremendous merit. Taking the idea from the success in Britain (eg Dr John Marks), today we see a method that has evolved across Europe; the Swiss, the Dutch, the Germans and the Danes, among others are all doing it – treating thousands of clients and with great results. So it was more than frustrating to hear that our own diamorphine clinical trials had been closed this year with no plans to restart them.

Diamorphine should not end up marginalised and discarded because a controversial new 'system' finds it far harder to tolerate than the patients who receive it do. The benefit is proven. It's not a choice between maintenance and abstinence. Addiction is not reductive to either/or and, as treatment is neither just a science nor an art, clinicians should not be restricted to methadone or subutex, or our clients subjected to a binary 'take it or leave it' choice in services.

Erin O'Mara is editor of *Black Poppy* magazine and it currently volunteering at Release

More on harm reduction at:
www.drinkanddrugsnews.com

BUCKING THE TREND

Unlike in England, drug deaths in Wales have been falling since 2010 – a result that can be traced to Welsh public health policy and harm reduction practice, say **Josie Smith** and **Chris Emmerson**

AS PREVIOUSLY REPORTED in *DDN* (October, page 4), according to data from the Office for National Statistics (ONS), a total of 2,248 deaths from drug misuse were registered in England and Wales in 2014 – a rise of 14.9 per cent on 2013. Building on the near 20 per cent increase in drug misuse deaths from the previous year, a notable change in the pattern of drug deaths seemed to be emerging.

However, this paints an inaccurate picture. While drug misuse deaths in England have risen dramatically over the last two years, drug deaths in Wales have fallen year-on-year since 2010, with a 30 per cent decrease in the last five years to a total of 113 deaths – a rate of 3.90 per 100,000 population.

With drug misuse deaths in England now at their highest level over the 22 years for which the ONS publishes figures, the need for credible explanations for the rise became urgent.

One set of explanations has focused on changes to drugs and those who use them. The ONS, in the statistical bulletin (*http://bit.ly/1VyvAR9*) accompanying the release of the 2014 figures, points to changes in the purity of street heroin (as reported by SOCA, the UK's Serious Organised Crime Agency) as a possible influence on variations in drug deaths over recent years. Sustained rises in reported purity coincided with increases in deaths involving heroin/morphine in England. The ONS also suggests that, with increasing numbers of deaths among older drug users, the generation who began injecting in the 1980s and 1990s are aging and therefore at higher risk of dying from drug-related causes as other health problems take their toll.

However, the same ONS report provides another key piece of information that challenges the focus on changes to drugs and this demographic of drug users as key reasons for rising drug deaths. It comes on page 19: '...whilst drug-related deaths in England have now reached an all time high, those in Wales have fallen over the same period, down 16.3 per cent in 2014 to 113. Indeed, the rate of drug misuse deaths across the Welsh population, at 39 per million, is now less than England for the first time since 2004.'

With no reason to believe that either heroin markets or drug-using careers in Wales are substantially different to England, how can we explain the difference?

The second narrative to emerge following the release of the figures is that the difference is down to policy and philosophy. With health policy devolved within the UK, it is the Welsh Government that decides the priorities for substance misuse in Wales. In contrast to England, where – as reported in last month's article on the National Needle Exchange Forum meeting (*DDN*, October, page 16) – many users, frontline staff and managers are finding reduced funding and support for well-evidenced harm reduction approaches in favour of abstinence based 'recovery' models, Wales has maintained focus and funding for harm reduction.

In response to the release of the 2014 figures, deputy minister for health Vaughan Gething said, 'These figures represent lives lost to families and communities across Wales and while I welcome the news of a further decrease, any death attributable to drugs is one too many.

'Tackling drug misuse is a complex issue, which the Welsh Government has been working hard to address. The fact that drug-related deaths are falling at such a rate in Wales is testament to the significant work which we and our partners are undertaking.

'We are investing almost £50m a year in programmes including a bilingual substance misuse helpline, a take-home naloxone programme which reverses opiate overdose and the WEDINOS harm reduction project which tests substances. These figures show that this money is delivering tangible benefits.'

Also commenting on the figures, Josie Smith said, 'It is a testament to the National Substance Misuse Strategy in Wales, *Working together to reduce harm*, ongoing support for harm reduction services and a willingness to innovate new approaches to reduce risk, that have resulted in fewer drug deaths in Wales. Problematic drug use in Wales remains but the most severe of consequences, that of premature death, is declining through better engagement, appropriate and evidence-informed interventions and collaborative working.'

Josie Smith is head of substance misuse programme and Chris Emmerson is information analyst specialist at Public Health Wales

With drug misuse deaths in England now at their highest level over the 22 years for which the ONS publishes figures, the need for credible explanations for the rise has become urgent.

More comment and opinion at www.drinkanddrugsnews.com

FIRST IMPRESSIONS

The pressure to collect data from new clients should not replace essential rapport, says **Shahroo Izadi**

EMERGING HORIZONS' facilitators often begin training by asking delegates to describe why they do the job they do. Answers rarely deviate from themes such as being naturally engaging, an ability to build rapport, strengths in communicating empathy and a genuine desire to help.

These qualities are at the very heart of conducting an effective assessment, one that begins the non-judgemental process of supporting individuals to establish values, uncover strengths and build upon them.

Frequently, however, staff report that the rushed box ticking, contract signing and form filling required at first point of contact has become professionally debilitating. It seems widely accepted that therapeutic intervention begins during the second appointment (provided the client has come back).

Despite positive improvements across the substance misuse sector, it seemingly remains widely acknowledged that traditional health and social care assessments are too focused on deficits and inadequacies, with some practitioners expressing concerns that their deficit-based assessment procedures may actually disempower and intimidate those who have found the courage to seek their help. Given the space to reflect, delegates often also realise how commonplace it has become for this crucial first meeting to be facilitated in a room 'decorated' exclusively in posters threatening certain death from overdose, HIV and hepatitis, often precariously tacked next to greyscale warnings of the latest bad batch of heroin in local circulation.

> 'It seemingly remains widely acknowledged that traditional health and social care assessments are too focused on deficits and inadequacies.'

Workers often report feeling pressured to hurriedly collect meaningful and reliable data on highly personal experiences such as sex working, abuse and illegal behaviour. Some staff have admitted during training that it was not until they had built rapport with their clients that they realised how much of the information collected at point of assessment was inaccurate.

Assessment protocols need to be systematically reviewed, updated and facilitated in a welcoming environment that models recovery. The paperwork should be designed as a tool to assist practitioners in collaborating with their clients on the development of a strength-based, person-centred recovery plan. For this to happen, even essential data capturing needs to be concise, accessible and client-led, as well as designed to focus on establishing recovery capital in areas such as relationships, social pursuits and life purpose.

Shahroo Izadi is development manager at Emerging Horizons, www.emerginghorizons.org

COLD CALLER

A craving is the salesperson we can choose to ignore, says **Chris Robin**

IT'S A FACT that a craving has to strike before a person uses drugs or alcohol, and that's why they can be terrifying for service users. A common technique in dealing with cravings is to distract the individual from their desire to 'use'. Yet, if someone avoids something the result is often a sense of fear, and from fear comes powerlessness. The substance user must be able to face their fear!

A craving is like a salesperson. Its purpose is to sell the thought of using to the customer and make it look attractive. It sells the idea of pleasure and euphoria. It doesn't talk about comedowns, or any other side effects, as that information would get in the way of the pleasure. The salesperson reminds the customer that if they use the product, it will change the way they view the world immediately, and that they will be stress and problem free.

> A service user will miss their drug of choice and experience longing and desire as well as grief for the loss.

In the break-up of a relationship, even if the decision to part was the right one, the parties will continue to yearn for one another, and the loss they experience will be extreme. This could be said of the service user's relationship with substances, as they will miss their drug of choice and experience longing and desire as well as grief for the loss. Cravings – the salesperson – will fully understand this and will know how to target those feelings, either blatantly or silently, to keep selling the product.

When we help service users to look at their relationship with a drug, it is important to acknowledge the yearning they may experience and the grieving process they are going through. Rather than distract them from these feelings, give them permission to be honest about the craving, so they can be aware of the sales pitch that is being used on them. This recognition will then inform the craving that it has been exposed, so it will have to become less blatant, more subtle, more silent, more devious, to make the sale. Again the worker's job is to help the service user to investigate these devious cravings so they can understand their sophistication.

Equipped with this information, the service user then has the tools to communicate with their cravings, stand up to them and say: 'I see you, I know your agenda, and I am no longer afraid of you!'

Chris Robin offers treatment and training at Janus Solutions, www.janussolutions.co.uk

Playing safe

Are we doing enough to protect children from their parents' drug and alcohol use? At a recent safeguarding conference there was plenty of cause for concern, as DDN reports

'Graham Greene said "There is always one moment in childhood when the door opens and lets the future in". We are responsible for opening that door,' Joy Barlow told the Adfam/*DDN Everybody's business* safeguarding conference, sharing her vision that we should refocus on the rights of the child.

The event brought together professionals with an interest in this sensitive issue and did not shy away from the challenging questions. Why were we missing signs that children were at risk? Were we aware that methadone soothing took place? How could we work more effectively with fewer resources? Why were we scared of even talking about this issue?

'This is one of the most difficult and fraught areas of practice,' said Barlow, who was formerly head of STRADA (Scottish Training on Drugs and Alcohol). 'We need to incorporate respectful uncertainty,' she said, quoting Dr Marion Brandon's research from serious case reviews. 'We need to demonstrate empathy and acceptance, but balance it with a healthy dose of scepticism... if the truth is not always presented to us, we have to ask why.'

Tackling safeguarding needed a fundamental shift in thinking, according to many of the day's speakers and workshop contributors. Nic Adamson, CRI director, said drug and alcohol workers 'often used to see it as their job to rock up and defend the client.' But this area required a different way of working: 'We need to learn to challenge clients' behaviour – really challenge it,' she said.

'It's a Pandora's Box – there's a fear in what we do,' said one delegate, and this theme kept resurfacing, in relation to safeguarding, methadone, and the delicate issue of challenging clients and asking them difficult questions.

'There are around 400 adult deaths involving methadone a year. Say this in the wrong room and you can be intellectually decapitated,' said Martin Smith of Derbyshire Safeguarding Team, who brought the risks to children into sharp focus.

'Hair testing has shown that methadone soothing is more common than we like to acknowledge,' he said. Examples from his caseload included a child death which the mother had said was accidental, but tests had shown the child had been routinely given methadone: 'A methadone storage box had been in place, she attended appointments, her engagement was good, there was a supportive grandmother – she gave the picture that all was OK.' In another case, 'a woman let a toddler ingest enough methadone to kill an adult'.

'We lack honesty and courage as a sector – let's not shy away from difficult challenges,' he said. 'It's really hard to hear the bar is so low in certain areas... we've all got work to do.'

Rachael Evans, policy and research officer at Adfam, brought evidence from case reviews that the charity had examined to produce the new report, *Medications in drug treatment: tackling the risks to children – one year on*. The main findings confirmed that there was insufficient appreciation of the dangers of OST by parents and professionals, and critical issues around safe storage. Practitioners were struggling to accept the idea of intentional administration of OST and felt that having these conversations might risk disengagement.

Austerity is 'the spoiler' that leads to 'the deadening hand of conflicting priorities'.
Pete Burkinshaw, PHE

'We're so busy we forget to ask the right questions,' commented Sue Smith, CRI's national safeguarding lead. 'But we need to challenge... it's our role.'

'I was bemused and shocked that my staff used to struggle around asking about safeguarding,' said Birmingham commissioning manager, Max Vaughan. But, he added, 'the combination of policing and being supportive can be really difficult.' It was about confidence, suggested one delegate, adding 'It shocks me that other agencies say "how do we ask those questions?" You just do. You have to.'

So apart from asking the right questions – about drug and alcohol use, drug storage, and making sure that risks to children were minimised – what were the key areas for improvement?

Better engagement between all of the professional partners involved with the family came high on the list.

In Birmingham, the safeguarding

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structure involved team leaders, who had been fully trained in safeguarding , providing real-time updates to social workers, explained Micky Browne, CRI's safeguarding lead. The Multi-Agency Safeguarding Hub (MASH) not only improved collaborative practice, but it also reduced inappropriate referrals, he said. 'The better agencies work together, the more efficiency will develop in the long term.'

DS Steve Rudd, of Birmingham police, added: 'When we sit round the Mash table now, we look a what's happening – do police actually need to run off and lock mum and dad up? In multi-agency working we all come from a different angle. We've developed an understanding of where we're all coming from and issues are very quickly resolved.'

Exchanging data that was easy to comprehend was key to creating multi-agency risk assessments, said Sue Smith. Joy Barlow believed that we needed to overturn our culture of 'educating in silos', bringing drug and alcohol content to social work courses. 'You've got to get people together in terms of learning and development,' she said.

The Federation of Drug and Alcohol Professionals (FDAP) were working with Adfam to develop standards and identify competencies that people working with families should all have, said FDAP's chief executive, Carole Sharma, who added: 'This sector has been guilty of generating mystique around ourselves. We need to undo this.'

Dr Judith Yates was hopeful that Adfam's new report would provide focus and remind commissioners of their power to make a difference.

'I remember the *Hidden Harm* report landing on my desk and it's stayed with me,' she said. 'Four years ago health visitors hadn't had training on alcohol. I hope Adfam's report will encourage people, including pharmacists, to talk to each other.'

Inevitably the question of diminish-

> **'This is one of the most difficult and fraught areas of practice.'**

Joy Barlow (below left), pictured with (clockwise) Sue Smith, Max Vaughan, Martin Smith, Carole Sharma and Judith Yates.

'I WAS SPOTTED, SUPPORTED AND ENCOURAGED'

In an emotional speech to the main conference, ***Ian Day*** *looked back to 12 years ago when he was 'deeply entrenched in addiction'.*

WHEN HIS PARTNER BECAME PREGNANT he made a decision to be 'a great dad' – but nine months later he was in prison.

'We slipped through the social services net,' he said. 'They had to be the enemy. But we were difficult people to work with.'

With his daughter taken into care he had spells of homelessness before being introduced to treatment service by an old friend, who was in treatment now herself and 'looked good'. This is where 'interventions came into play... it was a small window of opportunity to help a person. I was spotted, supported and encouraged'.

Six months out of treatment, he approached social services to try to win custody of his daughter who had been taken into foster care. He was 'not, on paper, the person you'd give custody of a child to' – 'at that time the reaction was "you're male", I had nowhere to live and I hadn't seen my five-year-old for three years. So I had to prove I could be that person.'

Securing a flat took two years, during which time he was tested continually by the agencies involved.

'I had to see my daughter in a room with a person taking notes – I was very nervous,' he said. 'I got enrolled on courses and at the time it felt very demeaning – they asked very obvious questions. It was very frustrating, but looking back it was the right thing because of my previous history.'

With 'all of the agencies speaking to each other throughout' he had his day in court and won custody. Now settled with his daughter and current partner of six years, he says he is grateful for the 'safe environment' created by agencies working in partnership, which led him to an outcome he never dreamed possible.

ing resources came up throughout the day, and PHE's Pete Burkinshaw described austerity as 'the spoiler' that led to 'the deadening hand of conflicting priorities'.

But Martin Smith urged delegates to remember that 'profit should never come before the needs of children'.

'We've got to have courage and honesty – and we've got to find evidence to back up what we're trying to change,' he said.

Among the challenging questions fired at the panel during the final session was the issue of whether children should be trained and supported to administer naloxone to their parent in the event of an overdose. Should they be given that responsibility?

While Dr Judith Yates was among campaigners who had welcomed the recent extension of naloxone prescribing, she was worried about 'children having to parent their parent': 'It depends on the age of the child,' she said. 'There's something not right about a six-year-old being entrusted to save a life.'

Martin Smith said the level of responsibility was too high, while Max Vaughan agreed 'it doesn't feel safe or right'. Sue Smith said that it shouldn't be entrusted to a child 'at this stage'.

But several delegates threw back a challenge of double standards, referring to the 'stigma of this client group'.

'Many children are left to manage chaotic drug use who haven't had proper support,' said one. 'Children, whether we like it or not, are managing their parents' drug use. We're guilty of double standards.'

At the beginning of the day, Joy Barlow had said: 'I'm elated at what we've achieved and also severely disappointed at what we've achieved' in this area of practice. Adfam's chief executive, Vivienne Evans, finished on an optimistic note by saying that workers in this field had passion and commitment, which was 'harder than rocket science'.

'This is hugely complex and difficult work,' she said. 'We need to have that optimism that we can give children the best start.'

'Workers in this field have passion and commitment, it's harder than rocket science.' Vivienne Evans, Adfam

A GRIM PICTURE

*Adfam's new report shows children are still dying after ingesting medications used to treat drug addiction. Its author **Rachael Evans**, Adfam's policy and research officer, shares findings*

ADFAM has particularly focused on safeguarding over the past couple of years. Publishing our new report *Medications in drug treatment: tackling the risks to children – one year on*, our research revealed that far more children than previously thought are dying and being hospitalised after ingesting medications prescribed to treat their parents' drug addiction.

In the ten years to 2013, at least 110 children and teenagers aged 18 and under in the UK died from the toxic effects of OST medications. In the same time, at least 328 children in England were hospitalised and diagnosed with methadone poisoning. Of the 73 deaths in England and Wales, only seven resulted in serious case reviews (SCRs).

Since Adfam first reported on this tragic phenomenon in 2014, these cases have continued to happen, with at least three new SCRs in the last year. While many children will have consumed the medications accidentally, some were given them by their parents in a misguided attempt to help soothe or send them to sleep. The statistics also show the majority of fatal poisonings involve older, rather than younger children – but little is known about how or why these incidents occur.

OST is proven to reduce dependence on street heroin, and by doing so it saves lives, improves health and wellbeing and cuts crime. The rightful place of these medications in addiction treatment is not at issue, but it's imperative that the risks they pose to children are better addressed and future incidents prevented.

Our report makes a number of recommendations to help do this, starting with the need for all incidents involving a child's ingestion of these medications to be fully investigated and recorded – and analysed centrally by government, with the learning shared with local services. The wide range of professionals who come into contact with parents and carers prescribed OST medications must all be trained about their potential harm to children, and services must work together and share information more effectively to minimise risk. Parents must also be educated about the potentially fatal risk posed by OST medications, and given a secure box to store them.

Vivienne Evans, Adfam's chief executive, said: 'The lessons from previous tragic cases have not been heeded, and a year after we called attention to the issue, children are still dying. The vast majority of parents prescribed these medications will use them safely and appropriately – but the number of children now identified as having been harmed lends the issue even greater urgency. Systemic and cultural failure means services are still not working closely enough to safeguard vulnerable children.'

Our research, along with the training we have delivered to local authorities, has identified some areas of good practice. One drug treatment service has appointed two specialist family workers to work with pregnant service users and families. Specialist

'Specialist workers and midwives can help a service maintain a whole-family focus'. Rachael Evans

workers and midwives can help a service maintain a whole-family focus, and this model was praised by SCR panels. Another promising model is the development of inter-agency joint protocols between drug services and health visiting teams, so that information is shared and joint home visits can be conducted. More information and examples of good practice can be found throughout the report.

By the end of 2015, Adfam will have trained 19 local councils to reduce the risks to children posed by these medications, and we hope to continue this crucial work in 2016.

TREAD SOFTLY

How can we tackle child safeguarding without risking disengagement? **DDN** hears a cautionary perspective from public health nurses

'THIS FOCUS ON CHILD PROTECTION is a good thing – but there are real consequences of focusing on it too much,' said Karen Hammond of the Centre for Alcohol and Drug Studies, speaking at the recent *HIT Hot Topics* conference in Liverpool.

Hammond gave insight into the changing role of public health nurses in relation to mothers who used drugs – and described a very fragile relationship. Having access to families had been seen as 'an opportunity for surveillance', with nurses expected to take on an additional social work role, reporting on cases that they felt were high risk.

The effect of this could be to breed an 'atmosphere of fear' and 'erode an already fragile trust', denying these women a valuable source of support.

One-to-one interviews with public health nurses who worked with this group of women revealed problems with engagement: women were tending to withdraw from contact with nurses, for fear of having their children removed.

This failure to keep appointments was being blamed on their engagement with drugs and the notion of their 'chaotic lives', rather than 'the cycle of fear and mistrust that had been created'.

The consistent issue to be highlighted was lack of training; many of the nurses had only had child protection as a training route to deal with these issues and thought they only needed to know about the names of drugs. This gave them perceptions such as: 'addiction results in a loss of control and affects the ability to parent properly'; and 'recovery is equated with abstinence' – so any continued use signaled danger to them.

Hammond relayed some typical comments from the interviews with nurses: 'The drug use takes over – that's all they think about,' and 'They want to stop it but they can't – the pull is just too strong.' Children were also still deemed to be at risk when they were not actually present during drug-taking, and had been left with family members. 'Nurses still thought [the mothers] wouldn't manage their intoxication and it would end in chaos,' she said.

> 'I asked for help and my children were taken off me. You're damned if you do ask for help and damned if you don't.'

'Overall it was quite shocking – the belief that drug use makes you a bad mother,' said Hammond. 'We need to not only teach parents about risks, but also be able to facilitate some critical self-reflection that's lacking at the moment.

'Professional practice should reflect the evidence base, not political or moral frameworks,' she said. 'What we really need is to dismantle prohibition – but in the meantime we need to recognise that the way we're dealing with it makes it worse.'

During the question time at the end of this session, a woman from Belfast commented: 'I asked for help and my children were taken off me. You're damned if you do ask for help and damned if you don't.'

More from Hit Hot Topics in our next issue

MEDIA SAVVY

The news, and the skews, in the national media

DRUG ABUSE AND HIV continue to present profound challenges to the health of gay people, but a climate of moral panic and blaming the gay scene is counterproductive... We need a more sophisticated analysis of the reasons driving high-risk behaviour among some gay men. Without this understanding, any future NHS responses to chemsex are destined to fail.
Marco Scalvini, *Guardian*, 10 November

A MAJOR REASON for the media coverage of chemsex as destructive is that most of the first-hand accounts of the experience come from people who present it as a problem at sexual health clinics. The media then select the most horrifying of these.... As for the connection between chemsex and HIV transmission, there is little academic consensus on this.
Jamie Hakim, *Independent*, 25 November

ADDRESSING CHEMSEX-related morbidities should be a public health priority. However, in England funding for specialist sexual health and drugs services is waning and commissioning for these services is complex. English sexual health services tend to be open access, with costs charged back to local authorities. Drug services tend to be authority specific with users having to attend a service within their borough of residence. Despite the different funding streams, creating centres of excellence for sexual health and drug services could be a cost effective solution to diminished resources in both sectors.
***BMJ* editorial, 3 November**

AROUND THE WORLD, about 25 countries including Australia, the Czech Republic, Portugal and Switzerland have initiated reform. Even Iran's theocracy brought in progressive harm-reduction measures and has influential voices calling for cannabis and opium legalisation. Slowly but surely we are seeing the end of stupid policies to prohibit drug use that are not only stunningly illiberal but damage users, families, communities and entire countries.
Ian Birrell, *Independent*, 9 November

IF GOVERNMENTS really want to limit the harm from drugs – saving addicts' lives, crushing dealers' profits and slashing the number of people who take them in the first place – then they must seize control of the market themselves.
***Economist* editorial, 7 November**

IF PEOPLE are going to use narcotics, it is best they do so safely. Relaxing the legislation on drug use, coupled with access to injection rooms, really is our only way forward.
Lorraine Courtney, *Irish Independent*, 6 November

WHAT DO MODERN TERRORISTS have in common? Yes, they are fanatical, and usually (but not always) from ethnic minorities. But there's something else very interesting. They are invariably on mind-altering drugs, usually cannabis.
Peter Hitchens, *Mail on Sunday*, 22 November

LEANER AND

In a climate of austerity the new drug strategy must grow from our successes, says **Paul Hayes** on behalf of Collective Voice

Next month the government will begin its formal consultation to inform the drug strategy due in March. So how far has the 2010 strategy delivered its aspirations, and what insights have the last five years given us to help shape drug recovery for the rest of this parliament?

In the 2010 strategy the home secretary set out an ambition to 'reduce demand, restrict supply, and support and achieve recovery'. The prime minister's view at the end of 2012 was that this had been achieved: 'We have a policy which actually is working in Britain,' he said. 'Drug use is coming down, the emphasis on treatment is absolutely right and we need to continue with this to make sure we can really make a difference.'

Despite the day-to-day challenges of delivery and the uncertainty of future funding following the spending review, we should not lose sight of the big picture – what the PM said was right in 2012, and remains right now. The policy is broadly achieving its aims and has been built on three pillars: a powerful positive narrative, endorsement of the clinical evidence, and a commitment to continue to invest.

The strategy successfully reframed the treatment system around recovery as an organising principle. The balance between ambition and evidence established a new consensus about best practice, steering clinicians to use opiate substitution therapy (OST) to provide a gateway to recovery for everyone who could take advantage of this opportunity. It also gave a secure place to build motivation and capacity to change for those not yet able to take the next step. This enabled the treatment system to promote recovery at the same time as continuing to deliver crime reduction and public health benefits – the bedrock of the success described by David Cameron, which it would be extremely unwise to unpick.

Crucially the government also backed the strategy with cash. Despite the extreme pressure on the public sector, funding committed to delivering the drug strategy was protected as part of NHS expenditure.

The 2010 strategy got the big calls right. It shaped a new ambition for the sector focused on the individual drug user, reached consensus on how to best achieve this together with wider societal benefits, and gave the resources to enable it to happen. However it also called for supporting action on jobs, houses, mental health, and a range of other crucial interventions which have not been delivered. The task for the 2016 version is to continue to deliver evidence-based, recovery-focused interventions, but to also overcome the strategy's failures in the following areas (see opposite for details):

- *Drug-related deaths*
- *Jobs and houses*
- *Integrating prison and community*
- *Mental health*
- *'Locally led, locally owned'*

Knitting all of this together would be health and wellbeing boards, which would integrate the local authority's concerns with the Clinical Commissioning Groups' (CCGs) continuing responsibility for drug users' physical and mental health, and police and crime commissioners' interest in the crime

'The ideal 2016 strategy would look very like its predecessor – the key difference being to identify how to deliver the joined-up services everyone has known we need for at least 30 years.'

KEENER

reduction yield from treatment. With some notable local exceptions, very few people would argue that the system is working on a national level. Health and wellbeing boards are understandably focused on social care as their overriding priority. Drug users are not a priority for either LAs or CCGs, and the decline in acquisitive crime which access to drug treatment has helped bring about has eroded the police's role as local champions of treatment.

Commitment to drug treatment varies among directors of public health who lead on this for local authorities. Public Health England (PHE) has disinvested from its local presence, limiting not only its ability to promote and share best practice, but also the local intelligence it previously provided which enabled Home Office and Department of Health to understand what was really happening on the ground.

From 2018, local control of public health will be further strengthened as the public health grant is replaced by direct local authority responsibility for funding from business rates receipts. Unlike in 2010, drug and alcohol treatment is no longer part of the protected NHS spend but will have to compete for resources in the much harsher local government environment.

Continuing to deliver what has worked and overcoming the deficits will become increasingly challenging over the next four years, as the cumulative 20 per cent real terms reduction in the public health grant, announced in the spending review, removes the stability of investment that underpinned the 2010 strategy. Investment in drug treatment increased threefold between 2001 and 2008, since when it has been broadly flat with a slight decline since 2010, and a significant shift of existing resources from drugs towards alcohol since 2013.

There will always be scope for more efficient use of resources, and the best commissioners are working with providers to use innovation and integration to sustain or even improve outcomes. However too often the response is mechanistic recommissioning resulting in wasteful churn, or to demand reductions in contract price only deliverable through reductions in the quality of delivery. The sector needs to collectively and realistically assess what can be delivered, and the new drug strategy provides a timely opportunity to match ambition with resource.

The ideal 2016 strategy would look very like its predecessor – the key difference being to identify how to deliver the joined-up services everyone has known we need for at least 30 years. Key to this will be how best to champion an agenda that is not a natural priority for most of the individuals and institutions responsible for its funding and delivery. Collective Voice will work closely with government to identify workable solutions to this long-standing problem on behalf of all providers and in the interests of service users, their families and their communities.

The 2016 strategy aims to overcome failures in:

DRUG-RELATED DEATHS

Until 2014 drug-related deaths were assumed to be in slow decline. Reversing the dramatic increases reported over the past two years has to be a key priority. The underlying causes of the increase are complex and probably result from the interaction of different factors, particularly the ageing and increasing vulnerability of the population. The first step must be to understand the phenomenon and then resource and implement evidence-based responses.

JOBS AND HOUSES

'Treatment success has been eroded by the failure to gain stable accommodation and employment' (*2010 drug strategy*). The very existence of Dame Carol Black's review is testament to the failure of the current strategy to route people via treatment into long-term employment that will help cement their recovery. Collective Voice's contact with Dame Carol and her team give us confidence that she will provide realistic and deliverable plans to promote access to employment, which if resourced will offer a new way forward. There is no such initiative, and therefore no similar optimism, on the housing front.

INTEGRATING PRISON AND COMMUNITY

The 'seamless transition' between prison and community sought by the strategy has not been delivered. Before 2013, prison and community treatment were commissioned as one system. They are now two separate systems, with NHS England responsible in prison and local authorities responsible in the community. The added complexity introduced by the 'rehabilitation revolution' has created even more opportunities for vulnerable prisoners to fall between the cracks on release.

MENTAL HEALTH

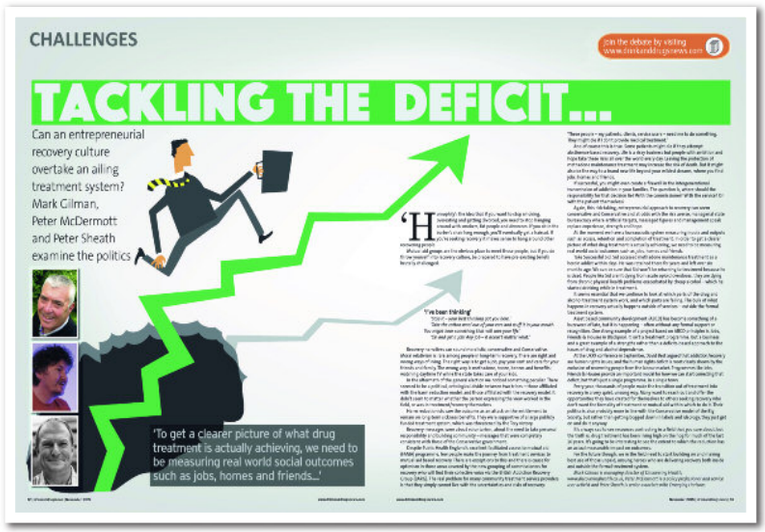
Every drug strategy has identified a failure to align mental health and drug services and none has been able to solve the problem. In essence this is because the root cause has been the NHS's consistent failure to invest in mental health services. The £600m investment in mental health announced in the spending review provides an opportunity to change this pattern, which we must seize.

'LOCALLY LED, LOCALLY OWNED'

Devolving responsibility to localities to enable 'joined-up local solutions' to replace 'one size fits all top-down targets' was at the heart of the 2010 strategy's approach to accountability. Local authorities were allocated treatment resources previously routed through PCTs in recognition of the NHS' historic reluctance to invest in drug and alcohol treatment and the potential to align drug investment with other LA responsibilities to provide cost-effective solutions.

Paul Hayes leads the Collective Voice project, a group of third sector treatment providers including Addaction, Blenheim, Cranstoun, CRI, Lifeline Project, Phoenix Futures, Swanswell and Turning Point

LETTERS AND COMMENT


CHALLENGES

Join the debate by visiting www.drinkanddrugsnews.com

TACKLING THE DEFICIT...

Can an entrepreneurial recovery culture overtake an ailing treatment system? Mark Gilman, Peter McDermott and Peter Sheath examine the politics

'To get a clearer picture of what drug treatment is actually achieving, we need to be measuring real world social outcomes such as jobs, homes and friends...'

MORAL MAZE

I was dismayed to read 'Tackling the deficit' (*DDN*, November, page 12). The authors (Mark Gilman, Peter Sheath and Peter McDermott, who told me recently that the article did not represent his views) referenced the importance of asset-based community development (ABCD) principles but, ironically, the entire piece was framed in divisive and deficit-focused terms.

Having thought we'd moved on from 'moral' narratives, with all their accompanying blame, stigma and discrimination, I read that 'There are right and wrong ways of living' and 'the right way is to get a job, pay your rent and care for your friends and family'. Many people, most on the wrong side of the poverty/inequality chasm in this country, are apparently living the 'wrong way', described as 'methadone, booze and benefits; watching daytime TV while the state takes care of your kids'. Try and find a focus on strengths (ABCD principles?) in that dehumanising and reductive statement.

According to Gilman et al you can reduce the huge diversity found within services and communities to 'two tribes' – harm reductionists are primarily concerned with a Conservative 'attack on the entitlement to remain on long-term sickness benefits' and the maintenance of a treatment system that 'has been living high on the hog for much of the last 20 years'; while those affiliated with the recovery model (note the singular) are closely linked (they make the link four times) to Conservative values and policy. This will be news to many people I know that work in services, desperately trying to offer support as funding is slashed, and to the many service users and recovery activists that I meet as I travel the country.

'Having thought we'd moved on from "moral" narratives, with all their accompanying blame, stigma and discrimination, I read that "There are right and wrong ways of living" and "the right way is to get a job, pay your rent and care for your friends and family".'

The suggestion by Gilman et al that these 'right ways of living' along with 'voluntarism...need to take personal responsibility and building community' are somehow the sole preserve of conservatives and in line with Conservative policy is again reductive, offensive and, in these austere times, rather bizarre. Jobs, friends and homes are central to recovery, as is social justice, and there is a huge amount of evidence that Conservative policy is impacting negatively on all these areas. Conservative policy tore communities apart in the 1980s, sowing the seeds of poverty and dislocation that we face today, and their current policy of disinvestment and privatisation is fuelling inequality and injustice at an alarming rate.

A version of 'recovery' (there are many) and ABCD is being promoted and used by some recovery capitalists for private gain, presumably in line with their neo-liberal values. They are providing cover, alongside those who remain silent, for the dismantling of a welfare state born out of a spirit of collective responsibility and community building in the 1940s.

However there are many people who are resisting this, whether they use the language of 'recovery' or not and the article by Gilman et al does them a great disservice. We can do better. There's a version of 'recovery' grounded in social justice and empathy.

Alistair Sinclair, director, UKRF

CAVALIER COMMENTS

I found two aspects of 'Tackling the Deficit' alarming.

Firstly, pitting harm reduction against recovery reiterates divisive and sterile arguments that very many of us had hoped were put to bed years ago. In addition, people who see harm reduction as one of the essential components of a comprehensive approach, along with many who are finding that ORT has helped to improve their lives, may well feel that the comment about 'entitlement to remain on long-term sickness benefit' is offensive.

Even more concerning is the apparent suggestion that people dying is a price worth paying. No it is not! Of course people choosing to move on from methadone should be supported to do so, but this must be within a system that helps them achieve this in as risk-free a way as possible. Too many people continue to die in the first weeks after coming off ORT or being detoxed.

Each drug death is a life wasted and a family devastated, and to make somewhat cavalier remarks about this issue is irresponsible.

George Allan, Ellon, Aberdeenshire

DEAD END

Despite the governments of Scotland and England being unanimous in the benefits of promoting naloxone to relatives and friends of people who are at risk of overdosing, there seems to be little attempt to get the information out there.

Many people use the telephone service FRANK [UK helpline] and Know The Score [Scottish helpline] for advice regarding substance use and rely on quality information being provided to them to help them to navigate themselves through very difficult situations.

They come through initially to a tier 1 adviser who can give them basic information regarding substance/alcohol use and then they will be put through to a more specialised adviser to help with further support, depending on the nature of the call.

There are some very dedicated advisers on both tiers but unfortunately, tier 1 cannot inform the caller about naloxone, either on FRANK or Know The Score. They can't mention naloxone on web chat

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.

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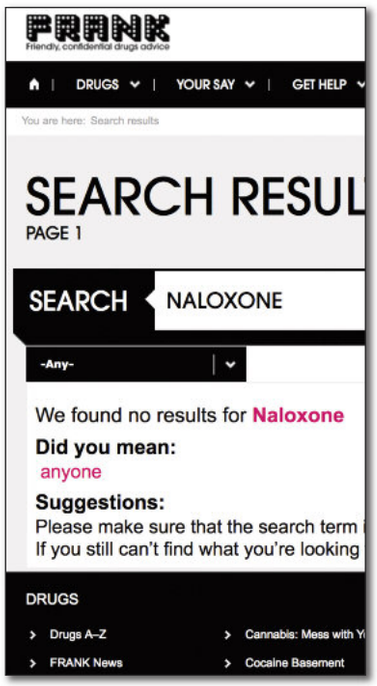


'The sense of relief is palpable in the caller's voice when they discover that an overdose does not have to end in fatality and that they are not totally powerless.'

either. Very often the tier 2 advisers are so busy that they can't get put through.

There have been cases where employees have had to break their remit and inform a caller about naloxone. The sense of relief is palpable in the caller's voice when they discover that an overdose does not have to end in fatality and that they are not totally powerless in the chaos round about them.

The problem is that FRANK and Know The Score discourage this and have ended people's contracts for mentioning naloxone and refusing not to give information. KTS and FRANK are run by Serco and neither Scottish Government nor PHE have briefed the employees. Most tier 1 employees do not appear to know what naloxone is either, and face being sacked if they do research and provide information on it.

No one from PHE or Scottish Government has responded to any of my emails asking for a remit to be given to FRANK or KTS on naloxone. I telephoned DAN [Welsh helpline] last night also and mentioned several times that my partner will not engage with any services and I was worried about her overdosing. They tried to signpost me to a service and I kept saying she wouldn't go and that I was really worried about her overdosing. After five minutes I asked why they hadn't mentioned naloxone – 'I'm not medically trained' was the answer.

Neither the Scottish Government nor PHE have got back to me, and the only response I have had was a verbal assurance from someone that they would bring this up with Serco at their next meeting.

Name and address supplied

LOSING BALANCE

I get *DDN* every month as I am very interested in all recovery from addiction issues. However, I am becoming increasingly dismayed by the increasing amount of articles, letters and overall focus on harm reduction. I believe there is a place in *DDN* and in the recovery world for harm reduction issues and articles, but not at the expense of balancing this with abstinence issues and articles. A year or so ago it was the same – then there was an abundance of articles about abstinence/recovery for a while, and now *DDN* seems to have swung back to harm reduction.

Can you and your editorial team please try and find some balance in this? I believe *DDN* was at its best between the swings when there was a more equal balance of articles about both of these issues.

Alex McKinlay, by email

FROM OUR FOREIGN CORRESPONDENT

Zero tolerance, zero cure

Russian drug policies are fuelling the escalating HIV epidemic, says **Chris Ford** with input from **Mikhail Golichenko**

LAST WEEK I ASKED VIKTOR HOW HE WAS, as his health seemed to be deteriorating. He relapsed again despite a desperate attempt to undergo drug treatment at Russia's most renowned drug treatment clinic, the National Research Center for Drug Dependence. He had started using 'khanka', which contains opium, aged 16 years, and then tried a number of other drugs, but he always went back to injecting opioids.

For the next few years he was in and out of prison, and then in about 2004 he found out that he was HIV and HCV positive. Prison was followed by several attempts at detoxification, as this was the only drug treatment available, but each time he relapsed.

Last October the Russian government's health committee held a meeting to discuss the rapidly growing HIV epidemic. The minister of health said that, at the current pace, the epidemic would grow 250 per cent by 2020 and any control would be lost completely – and suggested that HIV treatment coverage should be significantly expanded to include more people from vulnerable populations, including people who use drugs.

Authorities in Russia are aware that sharing contaminated injecting equipment remains the main driver of the epidemic. Despite this, Russian officials continue with their dogmatic approach to harm reduction and maintain a criminal ban on OST.

The Russian government argues that the legal ban on OST is to promote the right to health; the legal ban is mandatory for all, so there is no discrimination of any kind. The arguments that they present to the European Court of Human Rights (ECHR) are based on the notion that the low level of retention in abstinence-based treatment, which is the only method of treatment available in Russia, has nothing to do with the treatment's low effectiveness, and that people return to drug use because of their lack of motivation to stay abstinent.

According to the government, the introduction of OST will further demotivate people who use drugs from abstinence. Taking this one step further, the authorities insist that the awful health and legal risks people who use drugs face should scare and 'motivate' them into abstinence – in spite of there being no scientific evidence to support such an argument.

The ECHR hearings will take place sometime in 2016. Meanwhile, because of the government's stubborn resistance to OST, thousands of people who inject drugs contract HIV every year. The current denial of access to OST in Russia is not unlike the denial of access to antiretroviral therapy (ARVT) in South Africa at one time, when myths and ignoring clear evidence led to millions of unnecessary deaths.

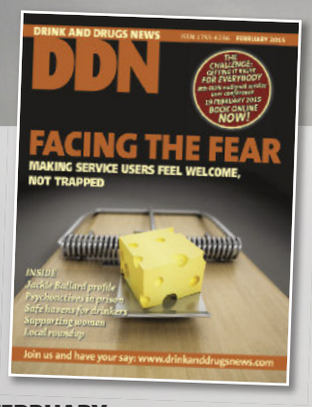
Mikhail Golichenko is at the Canadian HIV/AIDS Legal Network; Chris Ford is at International Doctors for Healthier Drug Policies (IDHDP)

DARK DAYS

There wasn't very much to celebrate in 2015, a year that saw both England and Scotland record their highest ever number of drug-related fatalities, while a surprise outright Conservative election win heralded yet more belt-tightening and austerity

JANUARY

Among ever-increasing fears about the impact of new psychoactive substances, the Ministry of Justice announces a raft of punitive measures for anyone found using or supplying them in prisons. 'If prisoners think they can get away with using these substances they need to think again,' warns justice secretary Chris Grayling.



FEBRUARY

DDN's eighth national service user conference, *The Challenge*, proves to be the liveliest yet, with a day of powerful presentations against a background of increasing anxiety in the field. DrugScope's *State of the sector* report indicates that the fears may be well founded, with more than half of survey respondents reporting a reduction in frontline staff alongside widespread concerns about job insecurity and rapid commissioning cycles. The highly controversial notion of linking treatment to benefit entitlement hits the headlines again as the prime minister commissions Prof Dame Carol Black to conduct a review into sickness benefits, while Alcohol Concern chief executive Jackie Ballard backs the call for health warnings on alcohol labels. 'Every other bottle of poison in the supermarket has a warning label on it,' she tells *DDN*.

MARCH

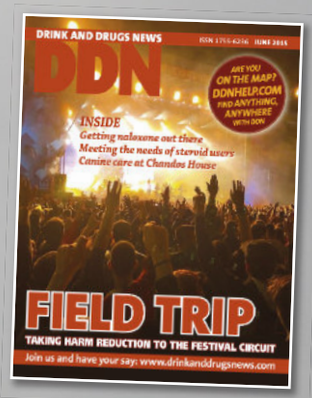
The government announces that it is developing plans for a general ban on the supply of all emerging drugs – the first stirrings of what is to become the controversial Psychoactive Substances Bill – and DrugScope goes into liquidation, blaming its worsening financial situation. 'It is with a heavy heart that the board has taken this extremely difficult decision', says chair Edwin Richards.

APRIL

Five more NPS become subject to temporary banning orders, and Alcohol Concern accuses the drinks industry of using responsible drinking messages as just another way to promote its brands. Meanwhile, Dr Joss Bray writes in *DDN* that it's time to put compassion back into service provision.

MAY

There's widespread surprise – not least within the party itself – when the Conservatives win a majority in the general election. The new government loses no time in announcing its 'landmark' blanket ban on all NPS, described by Release as 'full blown regression'.



JUNE

New substances are now being identified at a rate of two a week, the latest EMCDDA *European drug report* warns, although demand for heroin appears to be 'stagnating' across the continent. Delegates at the RCGP's national drug and alcohol conference argue that GPs need to stay central to substance treatment, while the 'Support. Don't Punish' campaign holds its third global day of action. Naloxone campaigner Philippe Bonnet, meanwhile, urges *DDN* readers to identify local champions, create networks and raise awareness of how cost-effective the intervention can be.

JULY/AUGUST

Bleak news as Scotland records its highest ever number of drug-related deaths, 16 per cent up on the previous year. The country still faces a 'huge challenge in tackling the damaging effects of long-term drug use among an aging cohort', says community safety minister Paul Wheelhouse. Prof Dame Carol black launches her review into 'supporting benefit claimants with addictions and potentially treatable conditions back into work' and ASH tells *DDN* that the Welsh government's plans to ban the use of e-cigarettes in public places amounts to a misguided attack on an effective harm reduction tool, although the claim in a PHE report that the devices are 95 per cent less harmful than smoking tobacco proves divisive.

SEPTEMBER

More grim news as England follows Scotland to announce its highest drug death toll – although fatalities in Wales are down – prompting Addaction chief Simon Antrobus to call on the government to re-think proposed cuts to local authority health spending. 'The stakes are simply too high to do otherwise', he states. The European Court of Justice deals a blow to Scotland's minimum pricing plans by stating that they could breach EU trade laws, while Portuguese health minister Fernando Leal Da Costa tells the pan-European *Lisbon addictions* conference that Portugal's decriminalisation approach is a 'sensible and rational' one that other countries could follow. Recovery month sees a vibrant range of activities across the UK, and Dave Marteau's *DDN* piece on the risks of diverted methadone ruffles some feathers.

OCTOBER

Another month, another stark report – this time from the ACMD, whose second publication on opioid replacement therapy for the Inter-Ministerial Group on Drugs warns that heroin treatment is being threatened by diminishing resources and constant rounds of 'disruptive re-procurement'. Another group of MPs, the Home Affairs Committee, concludes that the government is rushing, and weakening, its psychoactive substances legislation, while Phoenix Futures cautions that people's recovery is under threat from a 'perfect storm' of conditions in the UK's over-heated rental market.

NOVEMBER

Chemsex hits the national headlines when a *BMJ* editorial calls it a 'public health priority' and a scathing report from the Institute of Alcohol Studies says the government's 'laughable' public health responsibility deal for alcohol may be 'worsening' the health of the nation. Stirling University's Rowdy Yates tells *DDN* that it's time to get over the 'residential bad, community good' attitude, while Ian Sherwood writes that the sector needs to be braver in calling for drug law reform. The government's spending review makes more cuts to cash-strapped local authorities, sending further shivers through a drug treatment sector expecting the worst and increasing demand for a meaningful drug strategy in the new year.

DECEMBER

Plans are already well under way for the ninth national service user involvement conference, *Get the picture*. See you there!

OBITUARY

JUDY BURY

Chris Ford says goodbye to a passionate and inspirational colleague

It's with great sadness that we announce the death of Judy Bury, who died peacefully on 13 October 2015 in Edinburgh. Judy was one of the most inspirational, passionate and intelligent women I have ever known.

Judy started her career in sexual health services and always campaigned for the underdog. She was a proactive founder member of Doctors for a Woman's Choice on Abortion (DWCA) – always defending women's right to choice.

Later she became a hardworking GP in Craigmillar, a socially deprived area of Edinburgh, where she was a tireless and popular doctor. When the epidemic of HIV spread amongst Edinburgh's people who used drugs and gay men, Judy quickly became involved and before long was appointed GP facilitator to one of the first HIV facilitation teams, with the remit of educating GPs to cope with this new disease and manage people who use drugs in their practices. She was a brilliant teacher, and communicated effectively with fellow GPs, the community drug problem service and HIV agencies.

Before long, the Scottish Office asked her to help in the production of national guidelines for the management of drug users in general practice which, when published, were timely and well received.

Close to our SMMGP hearts, Judy was there at the beginning, helping to arrange both the first conference (now in its 20th year) and the newsletter. I remember her speaking at that first conference and saying we (general practitioners) needed to care for people and never judge them until they wanted to change.

Some of you 'young uns' might not remember her as she retired, because of ill health, about 11 years ago. But true to form even when unwell she fought tirelessly for the 'Yes' campaign in Scotland and gathered together a group of doctors to form Doctors for Assisted Suicide (DAS).

Judy always gave such a lot to people and causes she believed in. Many of us loved her, and after a difficult last illness she is at peace now.

Dr Chris Ford

FESTIVE CHEER

Lindsay Oliver tells us how Bubic are preparing to throw open their doors for Christmas dinner In their usual inclusive spirit

THIS CHRISTMAS DAY will see the fifth Bubic Christmas dinner for our service users. Previous years' events have been a huge success and provided a welcome and warm environment with a great community atmosphere.

Bubic (Bringing Unity Back Into the Community) is an award winning community-based organisation that provides support for drug users, ex-drug users, their families and friends. Our strength lies in our approach. We work in and around communities encouraging peer mentors to give those who are using drugs practical advice and emotional support to help change their lifestyle and learn life skills.

The Christmas Day event for our service users and volunteers is to help support them through an emotionally difficult time of year, with a full Christmas dinner served to 50 or more individuals. 'It's a worthwhile, charitable and peaceful event says Derwyn, a Bubic volunteer mentor and ex-service-user. 'I enjoyed being a part of last year's festivities and am eagerly anticipating this year's event.'

In true Bubic style, the event is a community initiative and is only possible through the donation of people's time and effort. A big thank you to organisations from within the community, including local Sainsbury's stores in Tottenham, who support Bubic through providing donations. Haringey Mencap not only donate the use of their beautiful Grade II listed building but also assist, alongside Bubic's staff and volunteers, in setting up for the event on Christmas Eve and provide transportation for our service users on Christmas Day.

John, a Haringey Recovery Service user, volunteered on Christmas Day last year. 'I was struck by the diversity of the group, from single men like me to single women and couples, from the elderly to families, people with young children and babies, to people whom society has chosen to forget,' he told *The Worm* magazine (featured in *DDN*, November, page 10).

Bubic prides itself on providing a platform from which members of our community can raise themselves up and aspire to greater things. Those who have previously encountered negative responses due to past behaviour and criminal records are given opportunity, and through proving their skills and abilities with Bubic, move onwards and upwards. Mark Nash, now a successful programme manager both in prison and the community, says, 'Coming through Bubic gave me a platform. If there was no Bubic there would be no-one to assist those coming out of prison.'

With Bubic gaining centre recognition from Gateway Qualifications, followed by direct claims status in 2015, we are now able to further build on this platform by providing relevant, recognised, bite-size qualifications that are achievable within a matter of weeks. These qualifications centre on increasing your confidence and self-awareness, learning new skills and enhancing existing knowledge with the goal of helping others within your community. They embody what Bubic is about and provide a recognised next step in the recovery process for our service users, as well as an opportunity for others to educate themselves and give back to their community.

We're also planning to further expand our outreach programme, which is essential to our organisation as it enables us to connect with the hard-to-reach clients; we bring the service to them. Our client Dodger recalls, 'Bubic have engaged me in the snow, when it was cold. They've come into crack houses and given me food and supported me in the early hours of the morning.'

We go where others fear to tread!

Contact Bubic at www.bubic.org.uk or 020 8808 6550 for further details about services – or if you are a service user in Haringey and would like to join them for Christmas dinner

The Christmas Day event for our service users and volunteers is to help support them through an emotionally difficult time of year, with a full Christmas dinner served to 50 or more individuals.

swanswell

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- AIRS workers – Bristol, Keynsham and Patchway (Ref 306) £19,000-£20,000
- AIRS Recovery Workers – Somerset, Bridgewater and Yeovil (Ref 307) £16,402
- AIRS Recovery Workers – Bristol, Keynsham and Patchway (Ref 308) £16,402

Swanswell is a national recovery charity that believes in a society free from problem alcohol and drug use; that everyone deserves the chance to change and be happy. Our friendly, professional team are committed to helping people turn their lives around. We know people are our greatest asset, so we recruit those whose desire to change lives for the better can help us make a real and lasting difference. In return we offer flexible working hours, a salary sacrifice pension, and a fantastic flexible benefits scheme.

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Alcohol and Drug Service, Tasmania, Australia

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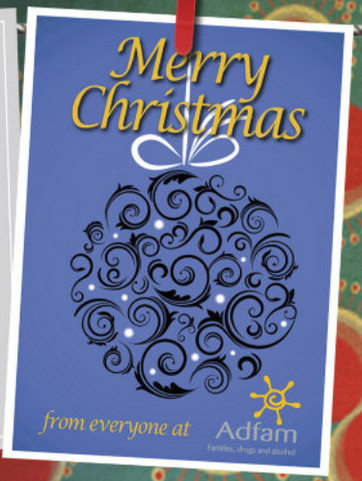
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This year's Christmas card was designed by the children at our National Specialist Family Service in Sheffield


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and a
Happy New Year


season's
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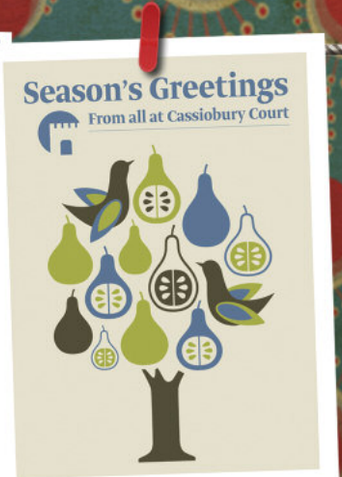
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