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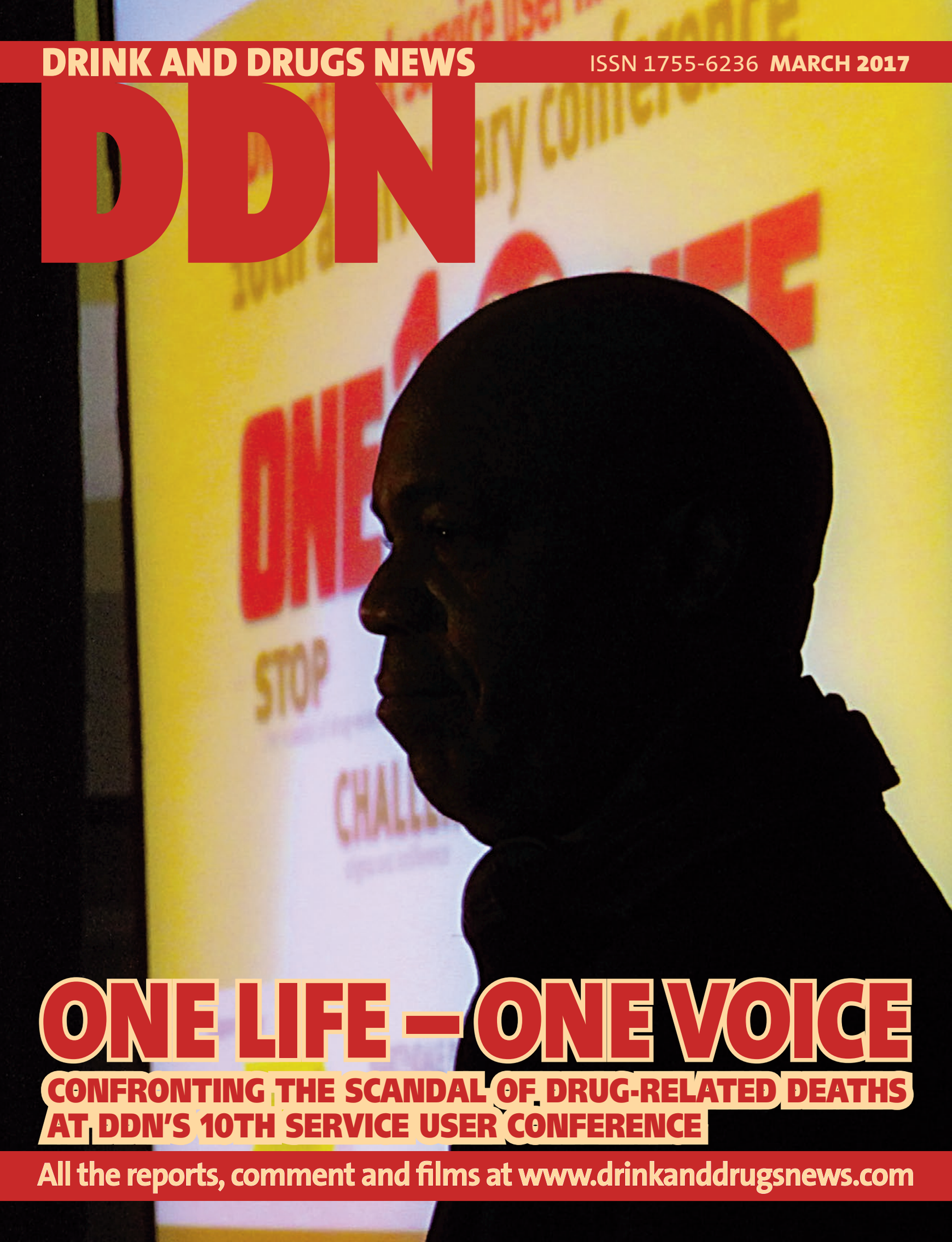

ONE LIFE – ONE VOICE

CONFRONTING THE SCANDAL OF DRUG-RELATED DEATHS AT DDN'S 10TH SERVICE USER CONFERENCE

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CONTENTS

Conference photography by Jez Tucker and Nigel Brunsdon

EDITOR'S LETTER

'One of the strongest messages was a simple one: isolation kills'

We had to make drug-related deaths the focus of this year's conference – we'd be living in cloud cuckoo land otherwise. The room was packed with people that were directly affected, as demonstrated by the question, 'who in this room has lost someone?'

We heard about keyworkers struggling with huge caseloads, and the state of constant recommissioning – identified by the ACMD as a driving factor of DRDs. We were reminded that funding will drop further. But the take-home messages were clear: we need better integration between treatment services and the rest of the NHS, and we must do more to improve all-round physical and mental health.

Those who use substances and services must make their voices heard in the fray of local authority commissioning. 'Challenge cuts, challenge discrimination,' said our speakers. Central to this is making sure harm reduction is not sacrificed for short-term financial gain. OST, naloxone distribution and more injecting facilities were identified as vitally important – to public health as much as individuals.

One of the strongest messages was a simple one: 'isolation kills'. Most of those dying are not in services. Many of those who get a brief window of opportunity for treatment (say, while they are in prison) are not receiving it because the system is not ready for them.

So let's challenge locally. Find out who your commissioners are, and get involved in decision-making where and when you can. Let us know what's happening in your area and help us to highlight hotspots of strong and weak practice. Help us to improve the one tool we can all use – information. And let's carry on the networking that made this such a powerful occasion.

Claire Brown, editor

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

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DURHAM POLICE TO OFFER HEROIN-ASSISTED TREATMENT

DURHAM CONSTABULARY is planning to become the first police force in England to offer heroin-assisted treatment to problem drug users.

Under the proposals, people whose drug use has led to prolific offending would be able to follow a programme designed to 'stabilise their addiction in a controlled environment' and reduce their dependency until they stopped taking heroin altogether, said Durham police, crime and victims' commissioner, Ron Hogg. They would also be expected to engage with conventional treatment at the same time.

'I have asked our local public health departments to suggest a series of options which would enable us to introduce heroin-assisted treatment in the Durham area,' he stated, with the annual cost of heroin-assisted treatment estimated at around a third of that of keeping someone in prison. 'The aim of the initiative is to save the lives of addicts, shut down drug dealers and reduce acquisitive crime. Instead of stealing in order to fund their habit, and money flowing the organised crime gangs, addicts will be helped to recover. The costs associated with it would be saved through reduced costs in the longer term to the courts, prisons, the police, and wider society.'

Glasgow is also planning to open a consumption room and offer heroin-assisted treatment, after city officials approved the development of a business case late last year (*DDN*, November 2016, page 4).

The Durham scheme is likely to prove controversial, however, with an editorial in the *Mail on Sunday* stating that 'law-abiding, hard-working citizens whose taxes are used to pay for heroin may feel they have been mugged by the taxman to pay for someone else's bad behaviour', and adding that the 'biggest objection' was that the plan was sponsored by a police force. 'Their job is to uphold the law,' it said. 'They cannot actively help people to do something that would be illegal in other circumstances. It is a step too far.'

'The aim of the initiative is to save the lives of addicts, shut down drug dealers and reduce acquisitive crime.' RON HOGG

PURITY UP

HEROIN, COCAINE AND MDMA are now being sold at 'unprecedented' levels of purity, according to the latest DrugWise survey of the UK's street drugs market. This confirms a trend of rising purity levels detected since 2014, says *Highways and buyways: a snapshot of UK drug scenes 2016*, which is based on interviews with police officers, treatment staff and others. While heroin purity had reached 40 per cent three years ago, following the 'drought' of 2010, purity levels of up to 60 per cent are now being quoted, the document states. It adds that while the 'primary aims' of last year's controversial Psychoactive Substances Act (*DDN*, June 2016, page 4) had been achieved – closing 'head shops' and stopping chemists from simply tweaking the formula each time a drug was banned – synthetic cannabinoids have now become firmly established as street drugs in some areas, causing 'continuing problems for vulnerable groups' like rough sleepers and prisoners. *Report at www.drugwise.org.uk*

STREET SCENES

ALCOHOL ADVERTISING SHOULD BE REMOVED from streets, parks and public transport, says a report from Alcohol Focus Scotland. *Promoting good health from childhood* also wants to see a phasing out of alcohol sponsorship in sports, music and cultural events, as well as further advertising restrictions for social media, print, cinema and TV. 'We allow alcohol companies to reach our children from a young age,' said chief executive Alison Douglas. 'They are seeing and hearing positive messages about alcohol when waiting for the school bus, watching the football, at the cinema or using social media. We need to create environments that foster positive choices and support children's healthy development.' *Report at www.alcohol-focus-scotland.org.uk*

WORKERS' RIGHTS

A NEW GUIDE to the legal framework around sex work has been published by Release. As well as setting out the criminal offences, *Sex workers and the law* includes advice on issues such as welfare benefits, dealing with the police and going to court. The guide is aimed at people engaged in sex work as well as statutory and voluntary agencies and professionals who come into contact with those in the sex industry. *Documents at www.release.org.uk*

SUBSTANCE STRESS

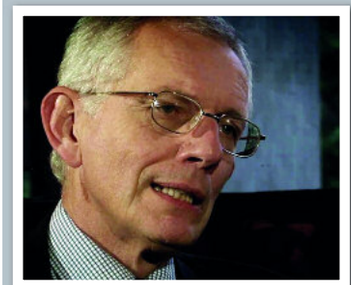
A THIRD OF RELATIONSHIPS affected by drug or alcohol problems will eventually break down, according to research by the charity OnePlusOne in partnership with Adfam. Of the survey sample of 100 people with substance issues, nearly 80 per cent reported arguing with their partner and more than 70 per cent said their relationship had been affected 'to a large extent'. However, more than 27 per cent said their relationship had become 'stronger' after seeking professional support. The research forms part of the DWP-funded Relationship Realities project, a collection of audio stories and practical advice from people in families affected by substance use. *www.adfam.org.uk/couple_relationships*

TAXING SUBJECT

INDUSTRY CLAIMS ABOUT ALCOHOL'S BENEFITS to the UK economy are 'overstated', according to an Institute of Alcohol Studies (IAS) report. Alcohol is now 60 per cent more affordable than it was in 1980, says ***Splitting the bill: alcohol's impact on the UK economy***, and any drop in consumption as a result of increases in cost are likely to reduce the estimated £8-11bn annual impact of impaired productivity, alcohol-related ill health, unemployment and premature death. 'Economic arguments are regularly used to resist policies that tackle excessive alcohol consumption, such as raising duty,' said IAS policy analyst Aveek Bhattacharya. 'Yet raising the price of alcohol is more likely to benefit the economy than harm it, by reducing the productivity costs associated with workers' harmful alcohol consumption.' *Document at www.ias.org.uk*

'Raising the price of alcohol is more likely to benefit the economy than harm it.' AVEEK BHATTACHARYA

ALCOHOL DEATHS UP AGAIN



'We need measures which address the pocket money prices... the 24 hour availability and its heavy marketing.'

PROF SIR IAN GILMORE

THERE WERE 8,758 ALCOHOL-RELATED DEATHS IN THE UK IN 2015, according the latest ONS figures, a slight increase from 8,697 the preceding year. The figures are nearly double the 4,929 deaths recorded 20 years previously, however.

Nearly two thirds of the deaths were among men, and both male and female death rates were highest in the 55-64 age range. Scotland remains the UK country with the highest death rates, although these have been falling since their peak in the early 2000s.

'Despite recent falls in overall alcohol consumption, the upward trend of alcohol-related deaths persists,' said chair of the Alcohol Health Alliance, Professor Sir Ian Gilmore. 'We know that alcohol is the third largest risk factor for disability and disease, and the biggest risk factor for death, ill-health and disability for people aged 15-49. Yet the UK government has yet to implement the measures needed to lower this burden of alcohol-related mortality. We need measures which address the pocket money prices alcohol is being sold at, the 24 hour availability of alcohol, and its heavy marketing.' The alliance is calling on the government to introduce a minimum unit price, 'which we know would reduce consumption and in doing so, the attendant harm', said Gilmore.

A new lottery-funded website, Bereaved through Alcohol and Drugs (BEAD), has now been launched by Adfam and Cruse. The site aims to be a 'source of information, support and hope', and includes practical information, first-person accounts and other resources. 'For most of us, bereavement will be the most distressing experience we will ever face,' say the organisations, but the death of a loved one through alcohol and drugs can involve additional anguish through issues like stigma, shame and isolation.

Meanwhile, the latest Department for Transport figures show an increase in drink-driving casualties and no improvement in drink driving-related deaths since the beginning of the decade. There were 8,480 drink-drive casualties in 2015 – 3 per cent up on the previous year – along with around 220 deaths.

Campaigners have long been calling for the government to lower the drink-drive limit in England and Wales in line with other European countries. 'The government have taken their eye off the ball, and need to listen to the overwhelming evidence that a lower drink driving limit would save lives and improve road safety,' said senior research and policy officer at the Institute of Alcohol Studies, Jon Foster. 'There is huge professional and public support for this.'

Alcohol-related deaths in the UK registered in 2015 at www.ons.gov.uk. Reported road casualties in Great Britain: estimates for accidents involving illegal alcohol levels 2015 at www.gov.uk. BEAD website at www.beadproject.org.uk

CALL CONCERNS

THE NSPCC HELPLINE has received 25,000 contacts raising concerns over substance use near children over the last three years, the charity has stated – an average of almost one call per hour. The number of annual contacts has increased by 16 per cent since 2013/14, and the agency has made more than 20,000 referrals to external agencies such as the police and children's services. 'Drug and alcohol abuse can have hugely damaging effects around children, and it's clearly troubling to see a rise over time in reports of this problem to our helpline,' said NSPCC chief executive Peter Wanless. 'Substance misuse all too often leads to the neglect or abuse of a child and it's absolutely crucial that we do all we can to stop that.'

MONITORING THE MONITOR

PHE IS LOOKING FOR FEEDBACK on how National Drug Treatment Monitoring System (NDTMS) management reports are being used, and whether they are 'still fit for purpose' in the current operating environment. *Consultation available at https://surveys.phe.org.uk/NDTMS_reporting_consultation_2017# until 31 March.*

DRUG DATA

A COMPREHENSIVE ROUND-UP of new and previously published information on adult and young people's drug use in England has been published by NHS Digital. *Statistics on drug misuse, England – 2017* includes figures from ONS, NDTMS, crime surveys and more. Around one in 12 people had taken an illicit drug in the last year, it says. *Document at www.gov.uk*

COSTS OF A DRINK

THE FIRST MANIFESTO to help the estimated 2.5m children of heavy drinkers has been launched by the All Party Parliamentary Group (APPG) on Children of Alcoholics. The document calls on the government to develop a national strategy alongside properly funded local support, improved education and training for professionals, and better awareness raising for children. Children of alcoholics are twice as likely as other children to have problems at school, three times more likely to consider suicide and four times more likely to become alcoholics themselves, says *A manifesto for change*. *Document at liambyrne.co.uk*

PRISON PROMISES

THE GOVERNMENT has published its 'landmark' prison and courts bill, which it says will pave the way for the 'biggest overhaul of prisons in a generation'. The bill 'underpins' measures in the prison reform white paper (*DDN*, December 2016, page 5), setting in law for the first time that 'a key purpose' of prisons is to reform, as well as punish, offenders. Prison governors will 'take control' of budgets for health, education and employment, the government says, (*DDN*, June 2016, page 5), and 'will be held to account' for getting people off drugs and into work. Recent figures showed that deaths, suicides and assaults in the prison system all reached record numbers last year (*DDN*, February, page 4). *Prison and courts bill at http://services.parliament.uk/bills/2016-17/prisonsandcourts.html*

De Lima has conducted investigations into Duterte's involvement in extrajudicial killings.

PHONY WAR

HUMAN RIGHTS WATCH (HRW) is calling on authorities in the Philippines to drop 'politically motivated' charges against senator Leila de Lima, one of the few lawmakers openly critical of president Duterte's violent 'war on drugs'. Charges have been filed against de Lima for alleged violations of the country's drug laws, and if convicted she faces between 12 years and life in prison. De Lima has previously conducted investigations into Duterte's involvement in extrajudicial killings and links to death squads. HRW has also issued a report claiming that Philippine police are 'routinely' killing drug suspects in cold blood then falsifying evidence by planting drugs, guns and ammunition at the scene. *License to kill: Philippine police killings in Duterte's 'war on drugs' at www.hrw.org*

Power of TEN

The opening session of the tenth DDN service user conference mixed stark reflections on drug-related deaths and budget cuts with powerful exhortations to make sure the service user voice was properly heard

'Looking back over the last ten years, there's been so many cuts that I don't know what's left to cut,' Chris Robin of Janus Solutions told delegates as he introduced the opening session of *One Life*. Service users, however, had come a long way in those ten years. 'They know want they want, and they have a voice,' he said.

There had been far more money in the system a decade ago, he told the conference. 'But I'm not sure we made the most of the money we had, and maybe we're paying the price now.' Services had been forced into 'unhealthy competition' with each other, which inevitably meant that clients were losing out, while drug workers had huge caseloads and were effectively becoming mental health counsellors, housing officers and more in addition to their core work. 'Where do they get the time to actually talk about the client's drug use?' What's more, the workers themselves were also feeling extremely insecure about their future, he stressed.

> 'There's been so many cuts that I don't know what's left to cut.'
>
> CHRIS ROBIN

'We're seeing so many services being re-commissioned – there's a real need for stability,' he stated. 'And again, the honest question we have to ask ourselves is, "when the money was available, did we do the right thing?"'

The financial climate had forced services to be more creative and innovative, however, and to tailor their designs to the needs of their clients. 'It's no longer possible to get away with just offering generic services. We talk about the evidence base, but we have to open the door and create space for new kinds of evidence.

'There's nothing negative about service user involvement, but we can't allow a situation where service users are running the projects while the professionals sit back and let them get on with it,' he continued. 'We've got to give workers the power to be more authentic, and to relate back to what they see.'

One of the most disturbing developments in the decade since the first *DDN* service user conference has been the increase in drug-related fatalities in the last few years, delegates heard. 'At the ACMD [Advisory Council on the Misuse of Drugs] we're really, really worried about the trends we're seeing in drug-related deaths,' chair of its recovery committee, Annette Dale-Perera, told the conference. 'We advise the government. They don't listen to us most of the time, but we still tell them things.'

The ACMD had carried out work on opioid-related deaths because it was able to say things that Public Health England (PHE) couldn't, she told delegates. 'However, the data is not very good – it's based on coroner reports and it's not a consistent system. The data coming out of Wales is much better than what's published in England and Scotland.'

There had been 1,842 opioid-related deaths in England alone in 2015, she told the conference. 'That's massive.' Previously, the numbers had been increasing until 2001, the point at which more money started to come into the system and deaths had started to come down – 'a direct correlation', she said. The 'heroin drought' of 2009 to 2011 had also meant fewer fatalities, but the death toll had been increasing since then, she warned.

'Deaths in the under-30s have been going down – that's good, that's a success story – but deaths among the over-40s have been going up exponentially. Far, far more men are dying, but the numbers are creeping up among women as well.' The vast majority of those dying were either not in treatment at the time, or had never been in treatment, she stressed. 'Treatment is protective.'

Some of the deaths were undoubtedly being driven by supply – 'deaths go down when the heroin supply goes down' – and, worryingly, Afghanistan had seen 'bumper' opium crops recently (*DDN*, November 2016, page 4). However, many of the fatalities were the result of the impact of long-term heroin use and its associations with chronic health conditions, poor diet, smoking and heavy drinking.

Someone who had been smoking for 25 to 30 years would have a substantially reduced lung capacity, she said, which inevitably meant they were more likely to stop breathing in an overdose situation. 'Their livers are likely to be compromised as well, so it's the

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‘Deaths in the under-30s have been going down – that’s good, that’s a success story – but deaths among the over-40s have been going up exponentially.’

ANNETTE DALE-PERERA

combination with poor health and with mental health issues on top. Some people have got to the point where they don’t really care enough if they stay alive or not, and some deliberately overdose.’

Growing social deprivation was one of the key drivers, she warned, with deprived areas disproportionately suffering the effect of government cuts. ‘So it’s a double whammy.’

The ACMD also felt ‘quite strongly’ that another factor driving the deaths was constant re-commissioning, she said. ‘It’s creating transitions. People are being handed over from service to service, with different philosophies, different key workers, and the possibility of falling between the gaps.’ More cuts would inevitably be on the way, she stressed, with funding for treatment likely to reduce by 30 per cent by 2021. ‘We’ve lost harm reduction services. I’m very supportive of the recovery agenda, but we need harm reduction as well.’

The ACMD had told the government that it needed to do more to reduce supply, but its recommendation was also that levels of OST coverage must not be reduced. ‘We obviously need more coverage, not less,’ she said, but it was important that this went hand-in-hand with more action to prevent overdoses, such as naloxone provision and training, supervised injection facilities, and more to improve the physical and mental health of drug users.

‘You have a right to non-discriminatory treatment and healthcare,’ she told delegates. ‘Challenge these cuts, use your organisations, challenge discrimination!’

> Important though it is to get the messages out, it’s more important to mobilise people who can make things happen – the people in this room can do that,’ agreed head of Collective Voice, Paul Hayes. ‘You should get your voice heard, and challenge discrimination. Particularly in a local authority-led environment, if you don’t make your voice heard you won’t get the results you want.’

There was a moral obligation on everyone to concentrate on these ‘early avoidable deaths’ he said, but stressed that it was ‘not just’ about overdoses. ‘There’s a far larger number of hidden cases – people with compromised livers, lungs, hearts.’ In terms of practice, therefore, it was vital to ‘identify, integrate, intervene and engage’, he told the conference.

‘You need to identify the people most at risk. Treatment providers know where they are, and we need to spend more time and resources on them. We also need to make sure there’s much better integration between treatment services and the rest of the NHS.’ Links had become fractured through a lack of integration in commissioning, he said. ‘You can’t take the background pressure on NHS services out of the equation, but there’s no reason why we can’t engage with this and challenge those fractures.’ The fractured system between commissioning for treatment in prisons and in the community was also putting people at risk, he said.

‘If you don’t make your voice heard you won’t get the results you want.’

PAUL HAYES

‘The first thing that needs to happen is to engage with people outside the system,’ he said. ‘Our system has a penetration of 60 per cent – one of the highest in the world – but we need to engage with the other 40 per cent.’

In the summer, Collective Voice would be publishing a short document consistent with the clinical guidelines and evidence around best practice, he said. ‘We want to get this right. In too many places, what’s being commissioned is not consistent with the evidence, the clinical guidelines, or the 2010 drug strategy.’

Clearly, all of this was in the context of ‘very, very heavy’ cuts, which were only going to get worse, he stated. ‘The most important thing to hang on to is to protect access to evidence-based treatment. It’s interesting how the shiny new tends to drive out the boring old. The stuff that gets the headlines is consumption rooms and naloxone – they’re both important, but one of the reasons things are being cut is that drug treatment is not a natural fit with public health.’

Public health was ‘population-based’ he said, and the fact that the death tolls for tobacco and alcohol were far higher than for drugs inevitably meant they would be a higher priority. ‘But you have voices. You’re at risk. Your friends and family have died. These stories need to be heard – this has to be in the mix. I hope together we’ll be able to make some impact.’

Life and death issues

Drug-related deaths also dominated the day's *Big Debate* session, which gave delegates the chance to put their views across

The majority of people who die are out of treatment.
ALEX BOYT

'When people talk about drug-related deaths it's about numbers and systems,' service user rights advocate Alex Boyt told the conference. 'What we need to do is humanise it. I could have been a drug-related death, quite easily.'

'How many people do I know who've died?' said CEO of Build on Belief (BoB), Tim Sampey. 'There are so many that I can't remember all the names and faces. Drug-related deaths isn't just about heroin – it's a much, much bigger subject, and we need to be thinking much bigger.

'I ask myself, if I went into treatment now, "would it work?" I don't think it would.'
TIM SAMPEY

'What are the things that kill us?' he asked delegates. 'One is isolation. We need to be around other people – we're tribal creatures.' Another killer was undoubtedly stigmatisation, he said. 'We're the most stigmatised group in the country. Everybody hates us, and nobody cares. Everyone you speak to – who isn't one of us – thinks we've brought it on ourselves.'

The majority of people who died were out of treatment, Alex Boyt reminded delegates. 'It's great that people are having their ambitions realised in treatment, but you get people arriving in services who are broken, tired, fed up, and then they're given a whole new set of recovery challenges. There's something about the nature of services that is not holding and looking after people.'

'I ask myself, if I went into treatment now, would it work?' I don't think it would,' agreed Sampey. 'When I went into treatment in 2004 I had piles and piles of support, and it was the community of the drop-in that saved my neck. It's my grave fear that that's what's disappearing. For me, recovery is freedom from dependence and getting a life. It's not about abstinence or rules or regulations.'

The main indicator of whether an intervention would be successful was the quality of the relationship between

SOUNDBITES

'People are dying, and people are ill, and it's not OK.'
Dee Cunniffe

'You have voices. You're at risk. Your friends and family have died. These stories need to be heard – this has to be in the mix.'
Paul Hayes

'Commissioners sit in a town hall and it's very easy to cut things when you're not involved. I think it's crucial that they understand where the money's going, who it's for, and that they get some expert-by-experience knowledge.'
Becca, BoB volunteer

'Naloxone isn't a cure-all. It's just an excellent tool to have, alongside calling an ambulance, CPR and other things.'
Lee Collingham

'The majority of people don't have real discussions with their doctor about methadone or buprenorphine now, so what will it be like in a few years when there are something like nine different options available?'
Stephen Malloy

'You get people arriving in services who are broken, tired, fed up, and then they're given a whole new set of recovery challenges. There's something about the nature of services that is not holding and looking after people.'
Alex Boyt

'There's nothing negative about service user involvement, but we can't allow a situation where service users are running the projects

worker and client, stressed Boyt. 'But now it's in everyone's interest to under-report what's happening – it's this constant pressure on people to move forward. One manager said to me, "these days we have to get them in and out before we've even had a chance to get to know them". People also talk about hard-to-reach populations, but it's services that should be doing more to reach them. If you take a map of the drug-related deaths in the UK and a map of the areas of deprivation, they're exactly the same. Caring for each other sits at the centre of what needs to change in this society.'

'People will present with a mental health problem at their GP, but they'll be told they need to deal with their drug or alcohol problem first,' said one delegate. 'We should create more environments for people with both drug and alcohol problems and mental health issues, and let people know that having mental health issues is absolutely OK,' said Sampey.

One delegate agreed that 'measurements and targets for successful discharge' were driving drug-related deaths, while Andria Efthimiou-Mordaunt stated that 'one of our fellow activists died recently of a, quote-unquote, accidental overdose. We really need to talk honestly about the grief we experience because we don't really deal with it.'

Drug-related deaths had doubled in just a few short years, Boyt told the conference. 'If it was some other cohort of the population, that would be front-page news. It all comes back to stigma. As the older drug users are dying, it's almost like the authorities are just waiting till they're all dead, while constantly saying "we need to do more".' What's mad is that the people who are dying are not in service, while the naloxone doses are being given to those who are in service. But we're in a situation where the budgets are being cut so severely that people are just clinging on to what they do and not trying anything new. We need to be saturating the drug-using community with naloxone.'

'I've worked in this sector for a long time, and seen it grow from a cottage industry into something huge and commercial,' another delegate added. 'I think we need to re-humanise this industry. It's about people who want to get well.'

'What we've tried to do to reduce overdoses and drug-related deaths is put lots more into aftercare,' said Simon Cross of Yeldall Manor. 'But so many people in this country can't access residential treatment.'

On the question of aftercare, Becca, a worker at Build on Belief (BoB), told the session that, alongside increasing their investment in aftercare provision, commissioners needed to better understand what the lives of drug and alcohol users were actually like. 'Commissioners sit in a town hall and it's very easy to cut things when you're not involved,' she said. 'I think it's crucial that they understand where the money's going, who it's for, and that they get some expert-by-experience knowledge.'

'One of the things I say in my darker moments is that the powers-that-be are funding less and less, and caring less and less,' said Boyt. 'There'll be some areas where there'll be almost nothing left, so more and more will be relying on peer support. I think their role in aftercare is essential.

'I have sat in too many meetings where drug related deaths are discussed, he added. 'They always end with an acknowledgement that the figures will continue to rise. It's almost as if we are resigned to a whole generation dying so we can get the numbers back on track. Brutal stigma devalues the lives of many in the service user community and allows people to look the other way. We need to restore meaning to our losses. Instead of throwing statistics about, sometimes we must simply remember the special people we have known and cared for.'

'This isn't about numbers,' stated Sampey. 'It's about people we knew, cared about and loved.'

'It's very easy to cut things when you're not involved... it's crucial that they understand where the money's going'

BECCA

while the professionals sit back and let them get on with it.'
Chris Robin

'Aftercare is about peer support – and without it I wouldn't be here.'
Delegate

'You have a right to non-discriminatory treatment and healthcare. Challenge these cuts, use your organisations, challenge discrimination!'
Annette Dale-Perera

'There's a lack of honesty in treatment services. The voice needs to come from service users.'
Delegate

'It's easy for people to say "he was only a junkie wasn't he". I think of Alan, our colleague and friend.'
Beryl Poole

'We need to talk honestly about the grief we experience.

How many more people do we want to bury or cremate?'
Andria Efthimiou-Mordaunt

'Drugs or alcohol should never define a person.'
Delegate

'We're the most stigmatised group in the country.

Everybody hates us, and nobody cares. Everyone you speak to – who isn't one of us – thinks we've brought it on ourselves.'
Tim Sampey

'Keeping the memory alive is really important.'
Delegate

'Our aftercare runs for at least two years.'
Rachel, Ley Community

'We've got empty rooms all over the city – simple, safe, friendly places. They need to cost barely a penny – just a change of mind.'
Judith Yates

Advocating for change

This inspiring session heard representatives from user involvement and engagement programmes describe the power of effective partnerships

'We all need to make efforts to raise awareness... If you treat people now, they can be cured. This is about people, and real lives. Services are now expected to do far more with less.'

DEE CUNNIFFE

'We all need to make efforts to raise awareness and heighten perception,' policy strategy facilitator for the London Joint Working Group on Substance Use and Hepatitis C (LJWG), Dee Cunniffe, told the conference. 'People are dying, and people are ill, and it's not OK.'

Her organisation's mission was to prevent new hepatitis C infections in – and help treat – people injecting drugs in London. 'We also want to eliminate hep C as a public health threat among people who inject drugs,' she said. There was a 'massive burden' in terms of hospitalisations and deaths from end-stage liver disease, she stressed. In London in 2014, there had been more than 2,000 hospital admissions for people with hep C, with the virus also responsible for almost one in four first liver transplants.

The LJWG's objectives were not only to prevent further infections and increase testing, diagnosis and treatment, but to raise awareness of the public health threat, she said. The organisation was engaged in active case finding in needle exchanges and would soon publish a report on barriers to treatment, as well as a data linkage project.

In England, 50 to 80 per cent of injecting drug users became infected with hep C within five years of beginning to inject, and while there were 215,000 people with hep C in the UK, and far more effective new drugs available, health services were only financing the new treatments for a fraction of that number, she said. In London, there were an estimated 60,000 people living with hep C, yet the NHS target was to make the new treatments available to only around 5 per cent of that population. 'If you treat people now, they can be cured,' she stated. 'This is about people, and real lives. Services are now expected to do far more with less.'

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The session's other speaker, Mark Fitzgerald, described the hugely positive impact of getting involved with Mind Birmingham's flagship user involvement and engagement programme, Every Step of the Way, which trains, supports and empowers people with multiple needs, and is part of the wider, Big Lottery-funded, Changing Futures Together project.

'When people used to say to me, "you've got complex needs" I'd say, "of course I haven't – it's just addiction". But I ticked all those boxes.'

MARK FITZGERALD

The programme had finally allowed him to turn his life around, he told the conference. 'This is my 22nd year of sobriety, but even in all those years of sobriety I still had a lot of problems. I didn't drink, but I still didn't know what was happening in my own head. People used to say to me, "you've got a mental health problem" and I'd say, "of course I haven't, don't be daft".'

After years of 'trying to find out what was happening' he eventually came to Every Step of the Way, however. 'I told them, "after all my years of sobriety, here I am, and I want to get involved." They took me through the steps, and finally the penny dropped.'

He was assigned an engagement development worker who slowly guided him through the process, he said. 'I found out I'd had mental health issues from a young age, and that I did have complex needs. They help you move on with your own personal progression – after years and years of trying, in the last couple of years I've found out what makes me tick. I started reading all the books about mental health and depression and anxiety, and even though they were written 20 years ago it was as if they were written about me.'

The programme has not only allowed him to come to terms with his mental health issues, but to re-start his education as well. 'They pushed me in all sorts of different ways, and now I've got my diploma from college – I didn't think someone my age could get educated. It just gives you the chance to move on and progress with your life. After becoming sober after all those years of alcoholism I thought, "I've done it, I've done it", but I didn't move on, really. The last two years have been the best two years I've ever had.

'I've learned how to talk, how to engage, and how to not put obstacles in my way,' he continued. 'I didn't know I had the answers, but they've given me the knowledge to learn about myself and find out what's happening. When people used to say to me, "you've got complex needs" I'd say, "of course I haven't – it's just addiction". But I ticked all those boxes.'

The programme had finally allowed him to address and tackle his inner fears, he told the conference. 'It's only with the help of Every Step of the Way that I'm standing up here talking to you.'

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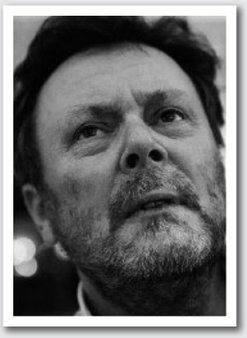
POST-ITS FROM PRACTICE

FINDING THE PIECES

One life, but many varied components to recovery as Dr Gordon Morse **reflects**



'No one even bothered to report them missing.'

John and Louise met under a railway arch in London; they shared an old mattress and slept under cardboard boxes. They had both run away from very abusive families – John from the West Country, Louise from Yorkshire. They left their homes when they were only just teenagers, completely under the radar of social services. No one noticed they had left, no one even bothered to report them missing. John hadn't been to school for years and was unable to read or write.

By the time that they met under that railway arch they were in their late teens, both with injecting heroin habits. Their relationship was more about self-preservation than anything else, and John started stealing more so that Louise wouldn't have to continue to sell herself.

After another year or two, they decided to move back to Somerset where John had friends. It was there, after Louise had been discharged following an emergency admission with another accidental overdose, that I met them, about eight years ago. I got them both titrated up to a proper dose of methadone and allocated them the support of a keyworker. Without the daily demands of miserable withdrawal symptoms, obtaining funds, using drugs and repeating this several times a day, they were able to take stock of their lives and what they wanted to achieve.

Opportunities are few for those with drug addiction, criminal records and health problems, and progress has not been quick – but it has been remarkable. When I last saw them, they had been housed in a tiny bungalow. John had been to literacy classes and they were both working in the local business – poetically, a cardboard packaging company – where Louise was supervisor. They lead quiet lives – John likes a bit of fishing, Louise likes walking their dog. They are both still on methadone, and when they come home from work each day, they still smoke a bit of heroin to ease old memories.

So Louise and John have come a very long way. OST hasn't achieved this for them – their own resilience and the opportunities offered by my colleagues have done most of that. And if anyone says to me that this is not 'recovery' because they are still smoking a bit of heroin, all I can say is that this story is the embodiment of what recovery from addiction really means – and I doubt it would have been possible without the stability and safety that OST has given them. Indeed I doubt that they would still even be alive.

Dr Gordon Morse is medical director at Turning Point and a member of SMMGP. First published in the IDHDP newsletter, March 2017.

MEDIA SAVVY

The news, and the skews, in the national media

FOR EVERY PIECE OF EVIDENCE showing that youth smoking rates have plummeted since e-cigarettes became popular, there is a blowhard in Philadelphia who insists that vaping is a gateway not only to smoking but to crack cocaine. For every report from the Royal College of Physicians showing that e-cigarettes help people quit smoking, there are a hundred activist-researchers in San Francisco claiming that vaping makes quitting more difficult... Teenagers experiment, and there is no doubt that they have experimented with e-cigarettes in recent years. The real question is whether they are experimenting with vaping instead of smoking or if the former leads to the latter. The drip, drip, drip of junk science from the US would have us believe that vaping is a gateway to smoking, but the empirical data strongly suggest the opposite.

Christopher Snowdon, *Spectator*, 8 February

I MAY NOT BE an enlightened non-drinker but I am an informed one. Sooner or later your vices catch up with you. The big bad medical wolves have achieved their goal. Dealing with unpleasant feelings seems a lot easier to me than any one of the ten horrible alcohol-related diseases I'm destined to get if I go back to drinking. So, I'm staying sober. For now.

Helen Kirwan-Taylor, *Telegraph*, 6 February

THOUGH THE PLIGHT OF ALCOHOLICS is awful – the demonisation by society (medical professionals included), cuts to mental health services, the ready availability of the drug... the list goes on – often overlooked are the struggles faced by their children... Local authorities require proper funding to deliver crucial physical and emotional support to children in need. It is only by reaching out to the children of alcoholics that we can hope to definitively break the cycle of addiction that has a stranglehold upon the nation.

Annie Beckett, *Guardian*, 27 February

LOCAL NEWS REPORTS [in the Philippines] of politicians found to be directly funded by drug money are so frequent, widespread and often absurd it's hard to know where to begin... So while Duterte's reprimanding of, and promise to cleanse the country of, crooked cops and officials will only add to his popularity among common Filipino people, I wonder if this is a fight he will stand by as firmly as his ferocious war on drugs. The deaths of more than 7,000 addicts and low-level dealers is one thing, but ruffling the feathers and incomes of the country's most powerful? That's an entirely different battle, and one Duterte should make sure he is squeaky clean for, because the most sinister thing about the Philippines' drug problem is not wild addiction statistics, but that there could be proof that corruption is endemic.

Joanna Fuertes-Knight, *Guardian*, 2 February

COUNTER

As the friendly and regular face at the heart of community-based medicine, the pharmacist has an opportunity to profoundly influence welfare. *DDN* reports

'If you're struggling, you say, "I'm alright". People pass you and ask, "Are you OK?" and you say, "Yes, I'm fine." It's just a normal greeting. But you could say, "You're going to wish you'd never asked me that. Do you really want to know? I feel like shit, I can't be arsed with anything, I'm just going through the motions."'

Lee Collingham is explaining how it can feel when you're trying to stay in treatment for problematic drug use. He speaks from personal experience and as a service user advocate and peer supporter.

'You may not have seen your drug worker for a month. You may have had a breakdown, got yourself back together, had another breakdown.'

And from his own experience: 'I've regularly started to miss doctor's appointments. Sometimes it's because it's the opposite week to when I get paid and I have to walk two miles. Or it might be because my appointment's at 8.30am and with me not sleeping well, I might have dropped off at 7am.'

He sees his local pharmacist regularly, just a short walk away, and points out that at the heart of an overloaded treatment system, the pharmacy has an increasingly important role.

'The pharmacy is central to everyone's treatment and they see people more often than anyone else in the system. So there's a lot of stuff they can do.' He reels off a list of basic interventions and harm reduction advice, as well as the opportunity to introduce patients to the right kind of hepatitis C treatment to suit their condition – 'if you're on OST [opioid substitution treatment] you get one kind of treatment, if you're a drinker you get another one, and so forth.'

But there's an overseeing role that can be equally important as far as he's concerned. 'The chemist is the one place they will attend regularly, and there could be better integration with other services,' he says.

'Some people might come in for daily OST pick-up on a Monday, then miss Tuesday and Wednesday. They're just keeping in treatment, but what are they doing for the other two days if they're not needing their script? Are they still using? It's not about checking people out, it's about helping them to reach their goals and where they want to be – about not making it problematic so they can't even come forward with an issue.'

Personally, he values the regular contact and the concern for his welfare – the little chat while waiting for medication to be made up. 'They'll say "are you alright Lee? You seem a bit quiet" or "you seem a bit off these last few days". It's the conversation that leads to help with all aspects of health and wellbeing.

'As services and needle exchanges are cut, your prime relationship is more and more with your pharmacist,' says Nick Goldstein, who is tasked with helping to make this relationship a positive one. Called upon as a representative of the drug-using community (a label he is uncomfortable with, as 'we're not all alike'), he is involved in an initiative by Martindale Pharma with Boots, supporting current and former service users to engage with pre-reg pharmacists as part of their addictions training programme.

Goldstein is cautious about overvaluing his role for several reasons. He is talking to pharmacists at the start of their career, rather than decision-makers in charge of culture change. He only has a slot of about half an hour in the training day – not enough time to go into the level of detail he would like, although questions from participants often take the session beyond its allocated slot.

'If I was cynical I'd say it was a case of saying, "hey, come and watch the bear dance". It's a show for them,' he says. 'In a dry academic day I turn up and I'm a little bit different. And they're always fascinated, always paying attention.'

But while paying attention, he hopes they are picking up the core points he's giving them – and while doing so, that the sessions are helping to address stigma and personalise the process of coming to the pharmacist for OST. 'I try to get them to look beyond the reductive labeling and see that we should be treated as individuals,' he says.

Beginning the training three years ago, Goldstein came face to face with the scale of his task.

'I realised after doing a few of these sessions that pharmacists have a huge miscomprehension about why people are actually in treatment – they seem to think we're there for one long party on the state,' he says. 'And you have to explain to them that that's not true, especially nowadays. No one goes into treatment

'The pharmacy is central to everyone's treatment and they see people more often than anyone else in the system... It's not about checking people out, it's about helping... They'll say "are you alright Lee? You seem a bit quiet".'

LEE COLLINGHAM

More on patient choice at
www.drinkanddrugsnews.com

CULTURE

for a gig or a good time. You're there because you've lost control of your life, basically. And that's a very scary thing.'

The stigma is not usually deliberate, but the product of 'a mixture of ignorance and apathy', he says.

'They have preconceived prejudices until someone points it out – that these people are more than the label you're slapping on them. They're people's husbands, fathers, sons, mothers, daughters, and they have careers and a whole range of interests, fears and fantasies. The difference is that they're addicted to drugs, but apart from that they are just like you. They're not from Mars.'

While they 'don't even realise beforehand that their attitude could be described as problematic', there's a slow dawning process that 'addiction's just a label and these are human beings just like them, and should be treated with the same respect'.

With chemist shops moving more and more into community-based medicine, we have a 'golden opportunity' to give pharmacists a better frame of reference for interacting with the community, says Goldstein.

In his short, rushed training slot, he is aware that staff from a large pharmacy chain are going to be restricted by standard shop layout and company protocol, relating to the routines they can influence – things like whether OST should be dispensed from a separate window – but he introduces the idea of ongoing dialogue.

'I'll say to the pharmacists, ask your clients what they want and at least take that into account when making your decision. Don't just present them with a *fait accompli* because that just disenfranchises people from the process and from the treatment.'

Both Collingham and Goldstein talk about the importance of fair play on both sides of the counter. Collingham mentions behavioural contracts as a way of establishing a respectful relationship, for example: 'I promise that I won't treat you like an idiot by stealing from your shop – and on the pharmacy side, I won't keep you waiting past clients that come in after you, or identify you as an OST user.'

Goldstein sometimes comes across pharmacists who are keen to share episodes of bad behaviour that took place in their shop, and agrees there are responsibilities that the client must sign up to. He reminds them: 'We are individuals. Some of us are fat, some of us are thin. Some of us are nice guys and some of us are assholes. Be clear about this – but believe in giving the assholes a fair break.'

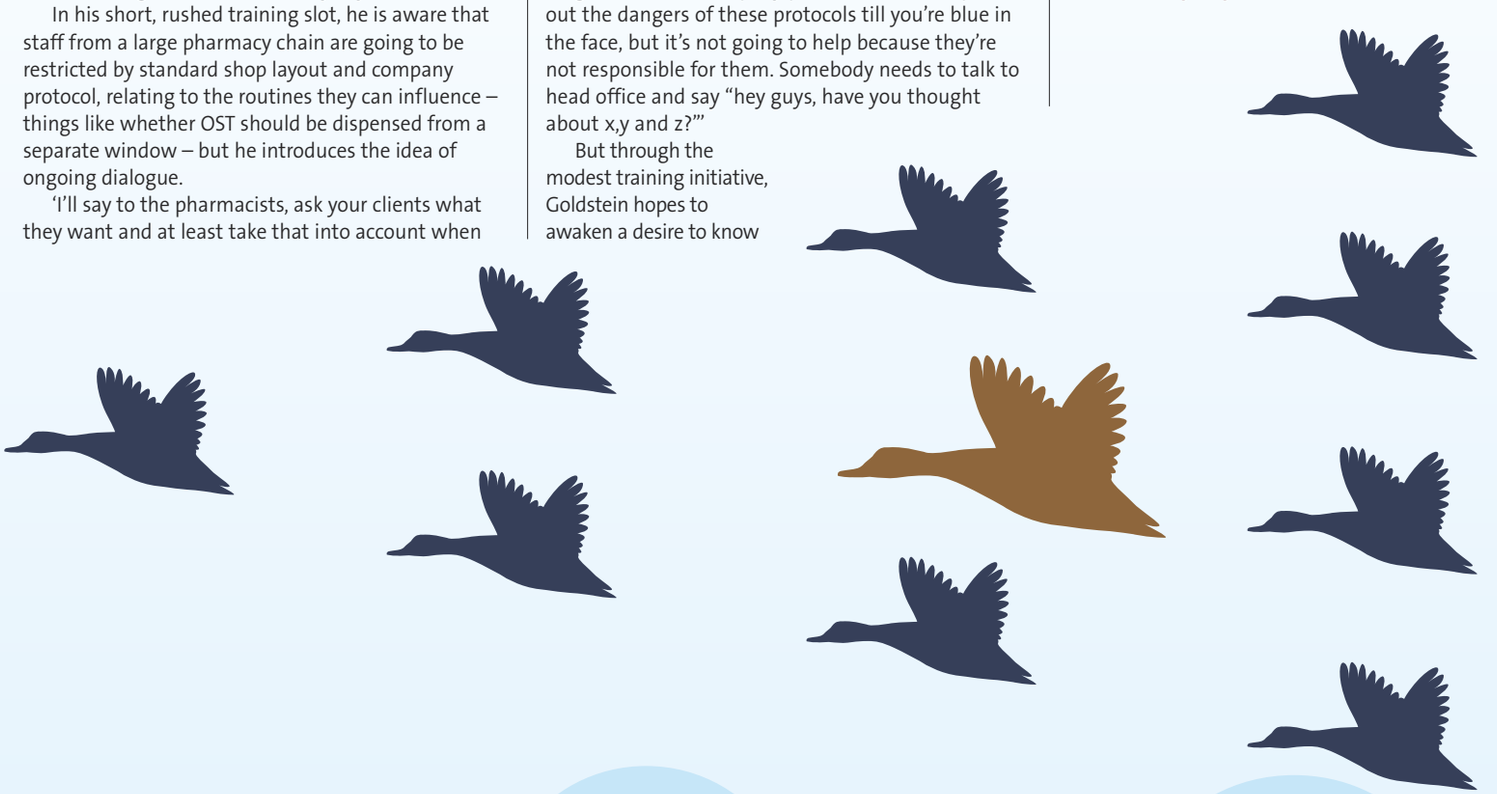
He is also acutely aware that pharmacists just entering their profession will have no influence over long-established company protocols. 'You can point out the dangers of these protocols till you're blue in the face, but it's not going to help because they're not responsible for them. Somebody needs to talk to head office and say "hey guys, have you thought about x,y and z?"'

But through the modest training initiative, Goldstein hopes to awaken a desire to know more – and there is a lot to learn. For instance, they are 'completely ignorant' about naloxone. 'Out of the few hundred I've trained now, I've had only two or three who know what it is. They're pretty clueless about it,' he says, adding, 'Naloxone is one of those things that should have been around for years, and now it's happening that's a great thing. But the way it's being implemented and put out there leaves a lot to be desired.'

In the limited time he has with the trainee pharmacists, he hammers home the increasingly important role they have to play: 'You see your key worker once in a blue moon. You see your consultant even more infrequently. You see your pharmacist fairly regularly, so I point out that they become a key point of contact in the treatment chain.

'And that can be the difference – their attitude and behaviour – between someone staying in treatment and someone leaving. That's the difference between life and death in some cases.'

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



SHARE AND CONNECT

At the conference's roundtable information exchange, delegates moved around the groups for ten-minute snapshots of different projects

ALCOHOL-RELATED BRAIN DAMAGE (ARBD) is a term for the damage that can happen to the brain as a result of long-term heavy drinking. **Notaro** homes showed how to spot the symptoms and find out how early diagnosis and referral to treatment can increase the chances of a positive recovery.

SOLVENT ABUSE continues to be a 'hidden' problem, with relatively few adult users finding their way into support and recovery services. **Nicola Jones** from **Re-Solv** discussed ways that local groups could use lived experience to connect with those in need of support.

NALOXONE is the drug that can temporarily reverse the effect of an opioid overdose. But how many naloxone kits were distributed in your area, who should you ask to find out, and how do you lobby for increased provision? **Lee Collingham** gave practical advice and easy to follow guidance (*on our website at www.drinkanddrugsnews.com*).

SERVICE USER INVOLVEMENT. Providing genuine, effective service user involvement within an organisation is not always easy, and can create tensions. **Sue Edwards** explained the process of creating an independent service user council that gives valued input to **CGL**, one of the UK's largest treatment providers.

SOCIAL ENTERPRISE. Self-funding a group through a social enterprise provides financial independence and valuable experience for its members, but sustaining and growing the business to be profitable can prove to be a challenge. **Changes UK** offered their experience as one of Birmingham's most successful social enterprises.

HARD-TO-REACH GROUPS may sometimes 'slip through the net' of traditional drug and alcohol services. **Aquarius' Shanti Project** explained how they tackle the taboo issue of alcohol misuse in the Punjabi Sikh community and discussed ways to work with other culturally sensitive minorities.

CONTINUED ENGAGEMENT. Recovery communities provide a fantastic, safe, supportive environment to help members build personal recovery capital, but it's of equal importance that groups continue to engage with people still misusing drugs and alcohol in an inclusive, non-judgemental way. **B3** shared ideas on how groups can support their members while involving those yet to find recovery.

ACHIEVING TRANSITION. Good rehabs ensure that aftercare is in place for clients leaving treatment and returning to the community. The **Choices** group of rehabs invited discussion on how to help clients achieve transition back to the community through a strong, sustainable recovery.

THE 12-STEP PROCESS. While millions of people attribute their ongoing recovery to 12-step based support provided by CA or similar fellowships, there are still misconceptions that can prevent some individuals or organisations engaging with them. **Cocaine Anonymous** tackled the myths and invited questions.

PATIENT CHOICE. Methadone maintenance and buprenorphine prescribing are evidence-based interventions that can bring stability and the first step on the road to recovery, but criticism is still levelled at maintenance treatment. **Stephen Malloy** of **INPUD** talked about patient choice, the right to OST, and following the path best suited to each individual.

NALOXONE TRAINING. Since October 2015 any worker in a commissioned drug service can distribute naloxone without prescription. This, coupled with the simplicity of administering the drug, gives the opportunity to provide simple practical naloxone training, as explained by **Philippe Bonnet** from **CGL**.

HEPATITIS C. New treatment options should ensure that no one should have to live with hepatitis C, but how do we make sure that treatment is accessible to those who most need it? **Dee Cunniffe** of **The London Joint Working Group** talked about making sure hep C treatment is not a lottery.

RUNNING A GROUP. Setting up and running a local recovery group is challenging. How do you support new members and cater for increased activities – and importantly, how do you fund this? **RED ROSE RECOVERY** have grown from a small local group to an organisation that works with some of the UK's largest treatment providers, employs more than 20 full and part-time staff and turns over nearly £1m. They explained how they achieved this without compromising their independence.

SEX ADDICTION can have a negative impact on the individual, their family and loved ones. Whether it's compulsive use of pornography, visiting sex workers, multiple affairs or any other kind of sexual behaviour, it is not always recognised by mainstream services. **Nic** and **Christine** from **Paula Hall Associates** looked at offering specialist treatment models and interventions.

Read the reports, see the pictures:
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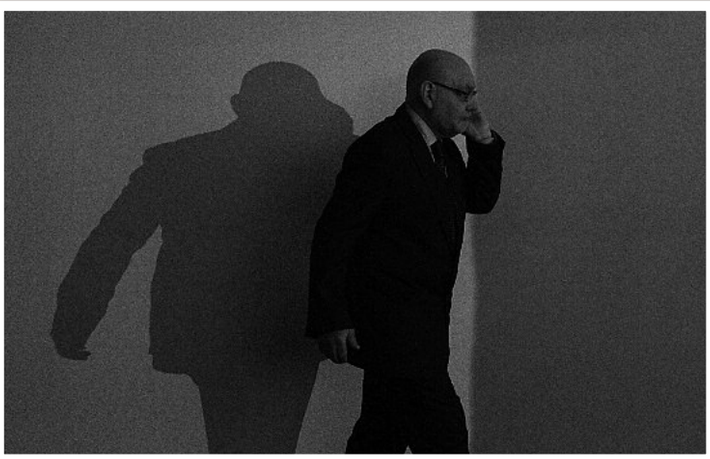
How we will act to stop DRDs?

At the *DDN* conference, head of Collective Voice Paul Hayes said it was important to mobilise people who could make things happen. Following the event, he sent this statement on behalf of Collective Voice, the NHS Substance Misuse Providers Alliance and PHE.



COLLECTIVE VOICE [a project representing a group of the largest third sector substance misuse service providers] believes that the most significant challenge facing the drug treatment and recovery system today is responding to the health needs of an ageing and increasingly vulnerable population. Moreover, that response must be formed in the context of declining resources and a fragmented delivery landscape.

The increasing fragility of the ageing cohort of heroin users who began their drug use up to 30 years ago has been highlighted by the Office for National Statistics (ONS) and Public Health England (PHE) as the main driver of the recent dramatic rise in drug-related deaths. These deaths, troubling though they are, represent only a fraction of the deaths among service users that Collective Voice members and colleagues in the NHS are witnessing. Given that being in treatment is demonstrated by the evidence to be a protective factor, the rise in deaths among the 40 per cent of heroin users outside the treatment system is likely to be even higher.

As providers of drug treatment services, we have a moral duty to examine and recast our own practice to minimise early deaths. As a campaigning body we have a duty to use our influence to reshape how services are commissioned, resourced and delivered to maximise our positive impact on outcomes.

Collective Voice has therefore come together with NHS providers and PHE to identify a shared agenda that can help minimise deaths. Two broad strands of activity will be undertaken focusing on improving internal clinical practice, and campaigning with others to improve the external environment.

With support from PHE, Collective Voice and NHS drug and alcohol providers will produce a shared Statement of Practice Principles which will:

Develop *and share management information systems able to routinely identify those most at risk of overdose and target resources accordingly.*

Publish *a guide to interventions, which draws on each organisation's clinical expertise and experience to delineate practice that minimises risk of overdose – including access to naloxone.*

Reframe *clinical practice with all service users to prioritise their physical and mental health needs, and identify how these will be met.*

Align *these interventions with the newly emerging Clinical Guidelines to ensure that good practice to promote recovery does not put patients at risk. Equally we will ensure that concern about drug-related deaths does not create a risk-averse clinical culture in which service users' legitimate ambitions for recovery are thwarted.*

Identify *opportunities to target and engage dependent users who are currently outside the treatment system.*

Vital though it is to ensure that the practice of drug and alcohol providers is the best it can be, deaths will almost certainly continue to rise unless the NHS significantly improves its response to this population.

Collective Voice will therefore seek to work with allies to influence the wider system in the following ways:

The current system is fragmented *and inefficient. It locates responsibility for commissioning drug and alcohol treatment in the community with local authorities, while service users' physical and mental health needs are met by CCGs, and prison services are separately commissioned by NHS England. The current system needs to be replaced with an integrated system able to ensure continuity of care between prison and community and respond in a timely fashion to the physical and mental health care needs of a challenging population all too often marginalised and underserved by a resistant NHS.*

Challenge disinvestment *by local authorities, which risks undermining the system's capacity to deliver the aspirations of the government's drug strategy and places unsustainable additional burdens on the NHS.*

Promote greater transparency *and accountability to ensure central government is sighted on the consequences for national policy of local decisions.*

Work to progress the Statement of Practice Principles will run during the first half of 2017, with publication planned for late summer. Seeking strategic change towards a better integrated system will be a priority for Collective Voice throughout 2017/18.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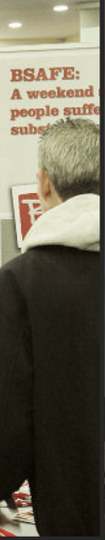


ONE 10 LIFE

THE TENTH NATIONAL SERVICE USER CONFERENCE

THE PLACE TO NETWORK

Once again the exhibition was at the heart of the event, with many opportunities to share ideas, learn about some incredible projects, ask for advice and expertise, and network with friends old and new.

There was the challenge of working off the authentic Birmingham Balti lunch with a game of table tennis, the space to relax with a head massage, or the chance to enjoy a mocktail and a movie, including highlights from the Recovery Street Film Festival. And let's not forget the annual challenge of cramming into the photo booth!

TAKE FIVE

Five minutes' training and an inexpensive kit is all it takes to save a life – so why isn't naloxone coverage countrywide, asks Philippe Bonnet after a non-stop day

I CAN'T BELIEVE THIS YEAR MARKS TEN YEARS OF THE *DDN* SU CONFERENCE IN BIRMINGHAM. How exciting and powerful. It has been a pleasure and privilege to attend this wonderful event.

I think it must be four years since I started training people on naloxone. The first couple of years were all about training individuals, without being able to issue kits. Last year, thanks to law changes, I managed to not only train but issued 35 kits as well.

I thought I might bring 50 kits this year, to see if I could beat last year's record. Within minutes, someone approached me, asking if I had kits to give out. They informed me they did not have naloxone in their town. I took them to my little corner and quickly trained them, and issued them with this life-saving medication. It was seconds before someone else saw me and asked me for a kit. And so it went on throughout the morning.

By lunchtime, I had issued 50 kits... and ran out! Then one of my colleague told me the organiser was looking for me, asking if I was ready for the afternoon session. I thought, o-oh, I have no kits left! Nevertheless, the session went ahead. I think I did my best to explain how sorry I was I could not issue them a kit, but at the same time I felt relieved that 50 people would leave Birmingham with a kit in their pockets.

None of the people I trained that day had naloxone, and they had come from all over the country. This made me realise how truly blessed we are in Birmingham. Our drug-related deaths have not risen, unlike the rest of the country. This is surely a testimony to all the hard work, commitment and pragmatism of my colleagues, from frontline workers to commissioning bodies, over the last five years.

To date, I must have trained around 5,000 staff across England and distributed around 2,000 kits to SUs. Naloxone saves lives. Full stop. And next year I will bring 100 kits with me!

Philippe is chair of the Birmingham Naloxone Steering Group and regional naloxone and NSP lead for CGL

FINDING BALANCE

Away from it all in the therapy room, Lois Skilleter and Sam Lofthouse gave delegates a taster of massage and Reiki

THIS WAS MY FOURTH YEAR of offering voluntary therapies at the DDN conference – it's becoming a wonderful annual event for me, and my students who have come have also enjoyed it very much. This year Sam accompanied me, and we were able to offer Indian head massage, Reiki and hand massages.

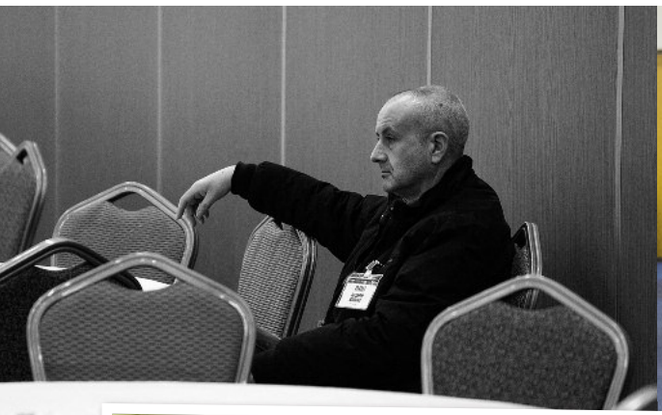
Indian head massage has only been around in the West for about 35 years, and is a very relaxing mix of the Indian traditions of hair oiling, chakra balancing and barbers' head massage, combined with the shoulder, neck and upper back massage that is so needed by westerners with our high stress levels. Our clients loved it and found they felt surprisingly lighter and happier after experiencing it.

Reiki is Japanese in origin and provides an energy balance, leading to relaxation and clarity of mind. Clients are often surprised to feel tingling or 'hot spots' even when the practitioner is not physically touching them. The practitioner is acting as a channel for the Reiki energy, allowing the client to draw what is needed through them – hence this treatment is very empowering for the client as they are in fact doing their own healing, with the practitioner merely a facilitator.

Hand massage is somewhat underrated, I feel: it's non intrusive, very versatile, yet can bring real relaxation to the recipient. Our clients who opted for this treatment really enjoyed it, noticing how much lighter and less tense their hands felt afterwards. I have recently done hand massage with a dementia group and both carers and patients found it soothing and helpful. It's also a good bonding therapy: some of the mums I work with like to do it for their children at night to help with sleep.

All of these therapies are gentle, relaxing and have few side effects, and can be used with vulnerable people as long as basic cautions are taken into account and a doctor's note received if the client is suffering from any contraindications. It is heartening to see complementary medicines becoming more accepted: while they do not replace medical advice and treatment, they can be a valuable support when used alongside conventional medicine.

Lois's website is www.earthereallofyorkshire.co.uk and she is always happy to discuss training and treatments.



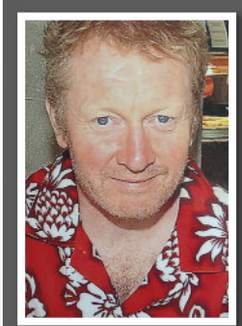
Read the reports, see the pictures:
www.drinkanddrugsnews.com

DDN would like to say
A HUGE THANK YOU...

to everyone who supported the DDN *One Life* conference: Our sponsors the 'I'm Worth...' campaign, Martindale Pharma, Public Health England. Our speakers: Chris Robin, Annette Dale-Perera, Paul Hayes, Mark Fitzgerald, Dee Cunniffe, Tim Sampey, Alex Boyt. Our roundtable participants from Notaro Homes, Re-Solv, NAG, CGL, Changes UK, Aquarius' Shanti Project, B3, Choices UK, Cocaine Anonymous, INPUD, LJWG, Red Rose Recovery, Paula Hall Associates. Naloxone trainer Philippe Bonnet; therapists Lois and Sam from Earthereal of Yorkshire; exhibitors and service user groups; our conference programme steering group; Paolo Sedazzari at Brand New Films; Nigel Brunsdon for extra photos; Dominic at simplyphotobooths.co.uk; and our indispensable volunteers and helpers: Lee Collingham, Kevin Flemen, Carole Sharma; Coventry Recovery Partnership – Simon Morgan, Bess Curtis, Adrian Hales, Adrian Mason, Sian Hails, Karoliina Wallace, David Ayriss, Louise Morley, Dave Smith, Mark Parrott, Steve Behal, Indy Thandy; everyone at the Changes UK Recovery Academy; The New Bingley Hall; and our tremendous delegates who braved Storm Doris to come from far and wide.

SEE YOU ALL NEXT YEAR!

MY DORIS DAY



Mark Reid, was among the many delegates to brave a battle with Storm Doris

'I LIKE IT WHEN IT GOES FAST' a little boy told his mum as the train to Birmingham slowed down again. The tannoy spluttered into life and the guard began to use the word 'adverse' a lot. Passengers went into the default mantra about Britain so easily grinding to a standstill. This time the caution was entirely called for.

As the taxi took me from New Street station to the *DDN* venue, it seemed to levitate as we changed lanes. By the time we tucked into the excellent conference curry lunch, people were sharing news alerts about the tragic death of a woman hit by flying debris, down the road in Wolverhampton.

For now I distracted myself fully in the *DDN* line-up of speakers and debates. The streets of stalls were packed with expertise. Thanks especially to East Coast Recovery, Liver4Life and ACT Peer Recovery for the great conversations. Just for a while I didn't think about the journey back.

I caught a bus to return to the city centre. There were weather diversions. The driver kept getting off to get directions from colleagues queuing ahead. 'I don't know where I'm going', he announced when he came back.

He did get us near New Street, where the gravity of the situation was stark: blank faces stared at blank screens. For the first time in my life I heard the announcement 'Come back tomorrow if you can'. There was a solitary route showing. I felt proud of that plucky little train to Walsall.

So began our mass route march to the next option: the National Express coach station, 15 minutes away. There were no coaches for anywhere near where I live. London was equally off the menu. A cry went up: 'Everyone for Leicester, over here'. For a few seconds, herd instinct kicked in and I nearly joined the line. Anywhere will do. It was then I first saw flickers of panic in people's eyes and heard a plaintive 'I just want to go home', from someone acting as everyone's spokesperson.

Onto my next big idea – the nearest Travelodge. It was either that or a taxi fare in three figures. The hotel was just a few minutes away. Brief elation – but it was full. 'There were 13 rooms left not long ago' the man at the desk mused. Thanks for that. 'Where's the next one, please?' 'The other side of the Bull Ring'. 'Can you check there for me?' He couldn't and I was rapidly taking a panicky dislike to him. 'But I can give you the number for central reservations'. Suddenly I loved him. I asked the lady on the bookings phone, 'Can you just work outwards from central Birmingham?' I imagined her warm and cosy office, everything calm.

They found me a room. I've never felt more satisfied reading out my long card number. You'd think I'd cracked the Enigma Code.

Mark Reid is a peer worker at Path to Recovery

FOUNDATION66

part of the Phoenix Futures Group

Experts in recovery for more than 45 years

At **FOUNDATION66** everything they are and everything they do is channelled into helping people affected by drug and alcohol problems to make positive changes in their lives. **Grace House** is **FOUNDATION66**'s female-only residential service providing drug and alcohol free support for women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders. Amy's story is typical of the opportunities offerered at **Grace House**

LIFE CHANCE

'It has been life-changing. I have been given the chance to build the future I deserve'

These are the words of Amy Munford, 27, after she spent nine months at Grace House, Foundation66's all-female rehab in Camden, North London.

Amy had been a heavy drinker and had suffered from an eating disorder since her teenage years, which became progressively worse through her time at university and into employment. Getting into an abusive relationship and surrounding herself with people who aided her addiction made matters worse and it wasn't long before Amy had deteriorated to the point where she was just surviving on drinking all day – her friends had deserted her and her family had no idea what more they could do.

With her health suffering to the point where she was unable to walk, Amy was referred by Westminster Drug and Alcohol Project to Grace House, where an all-female team provides friendly support to women with substance misuse problems and complex needs, including domestic violence, offending behaviour, sexual exploitation, homelessness and eating disorders.

Amy moved into the house, where she was assessed and given a personalised treatment and counselling programme that gradually helped her turn her life around. Looking back on her time there, Amy reflects: 'It was a wonderful community to recover in. I had enough freedom to grow and rebuild as a person and was able to input into my own recovery. Thanks to Grace House, I now have my health back, have been able to re-connect with my family and have built lasting friendships.'

'Amy's story shows how the philosophy behind Grace House really works.'

BEA WHEELER, LOCALITY MANAGER

Since leaving Grace House, Amy now has her own flat, at 'Amy's Place' (provided through the Amy Winehouse Foundation), is attending college and continues to have treatment for her eating disorder. She is now looking positively to the future, with plans to study further, move in to her own property and start a new career.

'Amy's story shows how the philosophy behind Grace House really works.' says Bea Wheeler, Foundation66's Locality Manager, 'A stable home is the basis for a successful and sustained recovery and Grace House provides women, like Amy, with the time, space and support to address their substance misuse and complex needs, to help them take the next step to a brighter future.'

If you would like further details on the **Grace House** service, either to refer, or self-refer, then please call on **020 7916 5013** or email **GraceHouse.Referrals@foundation66.org.uk**

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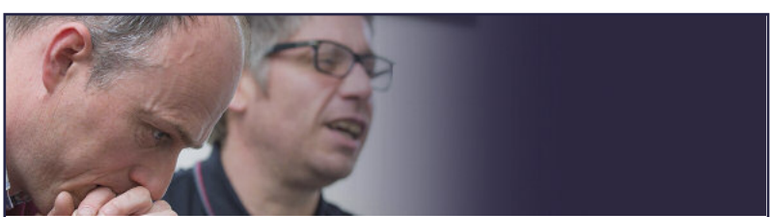

Gladstones

Would you like to be part of a team that counts on the professionalism, insight, expertise and passion of its staff to inspire individual recovery and promote positive change for the people they work with?

Gladstones Clinic is a specialist, private residential drug & alcohol Treatment Centre with two outstanding clinics based in West London and the Cotswolds.

With experience in the field of drug and alcohol addiction we are interested in hearing from dynamic, motivated professionals to join us in our innovative and cutting edge treatment centres. We are currently looking to recruit for the following positions:

REGISTERED CLINIC MANAGERS
CLINICAL ADMINISTRATORS
AD HOC PRESCRIBING CONSULTANTS
SPECIALIST GPS
FULL TIME NMPS
FULL TIME AND BANK RMNS
BANK SUPPORT WORKERS
FULL TIME THERAPISTS

For full details of these outstanding opportunities to help those in need and to join us in delivering an exciting and effective approach to treatment and recovery please see individual job listings on line at **www.drinkanddrugsnews.com/jobs**

For more information about our organisation please visit **www.gladstonesclinic.com**

BAC O'Connor

Choose the right road to recovery

BAC O'Connor have providing services for people with alcohol and drug addiction since 1998. Our Recovery-focused services include detoxification, residential rehabilitation, a unique resettlement programme offered through our Recovery Academy and Recovery Housing.

The O'Connor Gateway Trust provides a gateway to independence through the Recovery Academy – Homes, Jobs and Friends. Our Recovery Champions provide peer mentoring, operate RIOT Radio, work with partners including local hospitals and act as role models for abstinent recovery. We are recruiting for the following roles:

The Burton Addiction Centre Ltd

SERVICE MANAGER

£40-50k p/a plus benefits, Burton upon Trent
Closing date 24 March

A role which includes the operational management of the service along with Registered Manager responsibility. This is a front-line leadership role but the post holder must have a visible presence within each department including detoxification, therapeutic, residential and resettlement. The role has responsibility for all aspects of the day to day operations of the programme whilst ensuring that the quality of the services provided meets and exceeds the CQC Fundamental Standards.

Working closely with the directors the post holder will also be expected to contribute to the overall development of services, and to ensure compliance with the aims and objectives of the organisation.

SENIOR RESETTLEMENT SUPPORT WORKER

£20-22k p/a, Stoke on Trent with travel across Staffordshire
Closing date 31 March

An exciting new role has arisen which will involve leading and supervising, working closely with the Recovery Academy Manager, a team of Resettlement staff / concierge staff to support and enable service users to develop and enhance independent living skills and reintegrate back into the community, following an abstinence based rehabilitation programme from alcohol and substance misuse.

This role is all about empowering individuals to take responsibility through promoting choice and independence.

The O'Connor Gateway Charitable Trust

R.I.O.T. RECOVERY IS OUT THERE

BIG LOTTERY FUND

LOTTERY FUNDED

O'Connor Gateway Trust

RIOT CO-ORDINATOR (RECOVERY IS OUT THERE)

£18,000 per annum, Burton upon Trent
Closing date 24 March

We are looking for a dynamic, proactive individual to champion and further develop the O'Connor Gateway Trust's Recovery Is Out There (RIOT) programme. RIOT is a peer-led programme for people recovering from alcohol and drug addiction which provides information, advice and support.

The post holder will build on our existing Recovery Champions model to ensure visible contagious recovery at BAC O'Connor and across Staffordshire. The post holder will also have responsibility for the broadcasting and development of our internet-based Radio Station, RIOT Radio.

For more and to apply for any of these positions contact 01283 537280 or louise.watts@bacandoconnor.co.uk.