DRINK AND DRUGS NEWS ISSN 1755-6236 APRIL 2017

DDN

UNDER PRESSURE

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ON THE COVER

How much of a risk is Xanax?

EDITOR'S LETTER

'We need to understand the risks of Xanax and the culture behind it'

It's never easy to weigh up the level of drug risk based on America – remember the hysteria over crystal meth a few years ago, with drug services in the UK gearing up for the scale of devastation seen in some communities of the US? But with evidence of cases multiplying and including many young people, we need to understand the risks of Xanax (alprazolam) and the culture behind it. Anxiety is starting to be well documented, particularly among young people, and Xanax's link with celebrity makes it difficult to deter experimentation with the drug. Kevin Flemen's article (page 6) explains the nature of the threat and what to look out for.

Throughout the rest of this month's issue we talk a lot about prison – including the perspective of a service manager, who until recently was working at the frontline of prison substance misuse services. He feels compelled to share experience of clients being rushed through very intense treatment programmes, and of many opportunities for holistic interventions being dismissed or unsupported (page 16).

We can see the results of life-changing interventions through Addaction's Trans4orm programme (page 8) and RAPt's thriving apprenticeship programme (page 10) – both of which have the activities that are essential to self-sufficiency and self-esteem at their heart, and demonstrate results of properly supported initiatives. The other huge opportunity in investing in engagement with those in the criminal justice system is, as Charles Gore reminds us in relation to hepatitis C, to offer life-saving inventions and 'send people out of prison better than they went in'.

Claire Brown, editor

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

CJ Wellings

Published by CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT

Editor: Claire Brown
t: 01233 638 528
e: claire@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Advertising manager: Ian Ralph
t: 01233 636 188
e: ian@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
t: 01233 633 315
e: subs@cjwellings.com

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ALL PARTY GROUP LOBBIES PHE FOR PRESCRIPTION DRUG HELPLINE

THE ALL PARTY PARLIAMENTARY GROUP (APPG) for Prescribed Drug Dependence has set out its case for a national helpline for people struggling to withdraw from prescription drugs such as opioid-based painkillers, tranquilisers and anti-depressants. Prescribing for the latter has risen by more than 500 per cent since 1992, says the APPG.

Up to 10m people in the UK are taking benzodiazepines, sleeping pills, antidepressants or other psychiatric medications at any one time, says the group, while 10m people a year also receive opiate painkiller prescriptions. 'It is therefore proposed that the government should fund a national helpline to provide support and advice for this group of patients, most of whom have become dependent simply because they followed their doctor's advice,' it states.

A declaration of support for the proposed 24-hour helpline has been signed by leading medical bodies including the royal colleges of GPs, physicians and psychiatrists, while a recent meeting of the APPG heard from researchers at the University of Roehampton that around 770,000 long-term users of anti-depressants in England could be taking the drugs unnecessarily, at a cost to the NHS of £120,000 per day. Researchers also found that more than 250,000 people were taking benzodiazepines and 'z drugs' for more than six months, far beyond the NICE-recommended limit of two to four weeks.

The response of doctors and psychiatrists to prescription drug dependence varies widely, states the APPG, but is characterised by a 'lack of awareness and relevant training'. The absence of specialist NHS support means that those with dependency issues are reliant on small, struggling independent charities for help, several of which have had to close through lack of funding. The proposed helpline would be low-cost and could provide appropriate support during withdrawal as well as help with symptom management, says the APPG.

> 'Up to 10m people in the UK are taking benzodiazepines, sleeping pills, antidepressants or other psychiatric medications at any one time.'

'Long-term users of antidepressants, tranquilisers and opioid painkillers can suffer devastating effects when they try to withdraw, often leading to years of unnecessary suffering and disability,' said APPG chair Paul Flynn MP. 'And yet – unlike illicit drugs – there are hardly any dedicated services to support them. The cost of unnecessary antidepressant and tranquiliser prescribing is now estimated at £60m a year in England alone. We therefore urge Public Health England to set up a national helpline to support individuals wishing to withdraw from these drugs, and to reduce the tremendous cost to patients' lives and the public purse.'

PHE's director of alcohol, drugs and tobacco, Rosanna O'Connor has agreed to consult with colleagues about the proposal, the APPG has announced.

Call for national helpline to support patients affected by prescribed drug dependence (PDD) report at prescribeddrug.org

OLDER ISSUES

A NEW REPORT on the impact substance use can have on older carers has been published by Adfam. 'A family member's substance use is a difficult thing for anyone to deal with, and getting older can exacerbate challenges that put a strain on anyone, at any age,' says the charity. *No one judges you here – voices of older people affected by a loved one's substance use at www.adfam.org.uk*

NEW DIRECTION

PHE HAS ANNOUNCED A NEW THREE-YEAR CONTRACT for Mentor UK to expand its ADEPIS education programme, marking a 'significant move away' from 'hard-hitting' messages that risk proving counter-productive in trying to change young people's behaviour and attitudes. 'While encouragingly young people's use of drugs and alcohol continues to fall, the more common use of cannabis and the emerging risks from new psychoactive substances remain a concern,' said PHE's director of drugs, alcohol and tobacco, Rosanna O'Connor.

'We now have stronger evidence on what works to educate and influence young people's attitudes and behaviour on drugs and alcohol. I urge all local areas to support the use of the excellent ADEPIS programme in their schools and among community prevention workers.'

COLLECTIVE ACTION

COLLECTIVE VOICE is joining with PHE and NHS providers to identify a shared agenda to help minimise drug-related deaths. The organisations will develop and share management systems to target resources to those most at risk, 'reframe' clinical practice to prioritise the physical and mental health needs of service users, and publish a *Statement of practice principles*. '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,' says Collective Voice, with publication of the statement planned for the summer (*DDN*, March, page 7).

TIMELY THEMES

SUBMISSIONS ARE BEING ACCEPTED for the 2017 Recovery Street Film Festival, on the theme of 'making up for lost time'. This can be interpreted as 'things you wish you'd said, regrets, 24 hours you'll never get back' or anything else that participants find significant, say the organisers. *For more details or to make a submission visit www.recoverystreetfilmfestival.co.uk*

TIME TO SPECIALISE

SUBSTANCE USE SERVICES IN WALES need to adapt to meet the needs of the growing number of older people accessing them, and more specialist older adults' services should also be developed, says a Welsh Government-commissioned report from the Advisory Panel on Substance Misuse (APoSM). 'Substance misuse among older adults is a growing problem,' said public health minister Rebecca Evans. 'Levels of alcohol and drug misuse – including illicit drugs and prescription and over-the-counter medication – is a cause of concern.' *Substance misuse in an ageing population at gov.wales*

FRIENDLY FACES

A NEW ONLINE COUNSELLING SERVICE for gay and bisexual men looking for support around drug and alcohol issues has been launched by Terrence Higgins Trust and London Friend. Funded by PHE, Monday/Friday includes an online support group and one-to-one virtual counselling and aims to reach men in rural areas where support can be rare. 'If you find yourself stuck in a cycle, these online services can help you understand the role that drugs and alcohol are playing in your life and give you the knowledge and tools to make the changes you want,' said London Friend chief executive Monty Moncrieff. 'Wherever you live, and whether you want to cut back a bit, be safer or quit entirely, we'll be there at the click of a button to support, help and guide you through it.' *www.fridaymonday.org.uk*

> 'We'll be there at the click of a button to support, help and guide you'.
> MONTY MONCRIEFF

PHE LAUNCHES ONLINE NPS MONITORING TOOL

'We want to encourage all frontline staff... to use the system, which over time will greatly increase our knowledge of these new substances.'

ROSANNA O'CONNOR

A NEW NATIONAL SYSTEM to monitor the effects of NPS has been launched by Public Health England (PHE) and the Medicines and Healthcare products Regulatory Agency (MHRA). The pilot scheme will also share treatment best practice between drug services, A&E departments, prisons, sexual health clinics, GP surgeries and other settings.

All front-line health staff will be able to access the Report Illicit Drug Reaction (RIDR) system to anonymously report information about NPS and their effects, with the data then analysed to identify 'patterns of symptoms and harms'. The information will be used to improve patient safety, 'inform treatment guidance and help staff deal more quickly with unknown substances', says PHE.

While there is widespread concern about NPS use among vulnerable populations such as prisoners and homeless people, there is still little available guidance and the harms 'are often poorly understood' by frontline services, it adds.

'The contents of NPS frequently change and their effects can be dangerous and unpredictable,' said PHE's director of alcohol, drugs and tobacco, Rosanna O'Connor. 'Last year's ban has helped reduce their easy availability, but we are still seeing the most vulnerable groups – particularly the homeless, prisoners and some young people – suffering the greatest harm from these substances. We want to encourage all frontline staff in settings such as A&E, sexual health clinics, prisons, drug and mental health services, to use the system.'

PHE has also published its latest hepatitis C data, with the most recent estimates suggesting that around 160,000 people in England – and 214,000 in the UK as a whole – are chronically infected. Injecting drug use 'continues to be the most important risk factor' for infection, says the document. 'In 2015, 52 per cent of people who had injected psychoactive drugs, participating in the unlinked anonymous monitoring (UAM) survey of people who inject drugs, tested positive for antibodies to HCV, and this proportion has remained relatively stable over the past decade,' it states.

RIDR website at report-illicit-drug-reaction.phe.gov.uk
Hepatitis C in England: 2017 report at www.gov.uk

of a widespread reform of that country's drug laws. Drug-related deaths, crime and ill-health all continue to rise despite more than 80,000 arrests per year, says *Can Australia respond to drugs more effectively and safely*. *Report at australia21.org.au*

DRINKS MIXER

ALCOHOL CONCERN AND ALCOHOL RESEARCH UK have merged, the charities have announced. The merger will combine Alcohol Research UK's 'long history of research excellence' and Alcohol Concern's 'strong advocacy and campaigning work', with the latter's assets and staff transferring to Alcohol Research UK, along with projects like Dry January. 'The charities' mission and activities complement each other perfectly and we look forward to determining the future strategic direction of the combined organisation in the coming months,' said chair of the new organisation's board of trustees, Professor Alan Maryon-Davis.

MINIMUM ACTIVITY

ENGLAND AND WALES should follow suit if minimum unit pricing is introduced in Scotland and proves 'effective in cutting down excessive drinking', says a report from the House of Lords Select Committee on the Licensing Act 2003. 'It does not make sense for a decision for England and Wales to be postponed indefinitely,' says the document, although the legality of minimum pricing is still being considered by the UK Supreme Court (*DDN*, December 2016, page 4). *Select committee on the Licensing Act 2003: post-legislative scrutiny at www.publications.parliament.uk*

CIDER STRENGTH RULES

THE GOVERNMENT has announced a consultation on options to amend the alcohol duty system so that rates 'better correspond to alcoholic strength'. The consultation will look at the possible introduction of a new band to target 'cheap, high-strength white ciders' below 7.5 per cent ABV, as mentioned in last month's budget, along with a new wine duty band to encourage the production of lower-strength wines. *Alcohol structures consultation at www.gov.uk until 12 June.*

BIORESONANCE BUNKUM?

The controversial intervention 'bioresonance treatment' was called 'a new dimension in quackery' by an expert on BBC Radio 4's *You and Yours*. Edzard Ernst, emeritus professor of complementary medicine at Exeter University, commented on a programme from Castle Treatments, which costs up to £3,000 and involves wearing a pendant for 24 hours a day and taking detox pills. Researchers found the pendant to be made of plastic and incapable of giving off the promised 'resonance frequency' to 'neutralise addiction'. 'They say this is based on quantum physics, but it is based on pure bullshit,' said Prof Ernst. 'It is dangerous for your bank account and dangerous because if people are lured into bogus treatment they forgo effective treatment.' *BBC Radio 4's* You and Yours, *27 March episode, available on iPlayer*

LIBERAL MEASURES

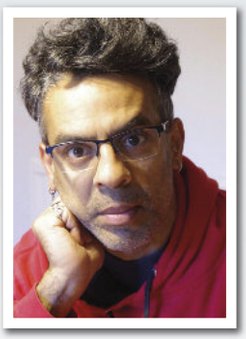
THE LIBERAL DEMOCRATS have called for the possession of drugs for personal use to be decriminalised as a way of easing overcrowding in Britain's jails. There are now more than 11,000 people imprisoned for drug offences, the party says, while the overall prison population in England and Wales has nearly doubled in three decades. Meanwhile, a new Australian report by former police commissioners, judges and other senior figures is calling for decriminalisation as part

NPS PERSPECTIVES

MORE THAN TWO-THIRDS OF YOUNG PEOPLE HAVE TRIED NPS 'AT LEAST ONCE' according to research commissioned by Addaction. While having to buy the previously legal substances from street dealers was regarded as an 'inconvenience', says the document, NPS use was also seen by young people as 'heavily stigmatised'. 'Frontline young people's services have been creative in adapting to meet these emerging needs even in a time of tight budgetary pressures,' said Addaction's executive director of external affairs, Karen Tyrell. 'It's vital that those changes are informed by what we hear from people who have used NPS.' *Novel psychoactive substances insight report: the view from young people at www.addaction.org.uk*

More than two-thirds of young people have tried NPS 'at least once'.

KAREN TYRELL



The celebrity craze for stress pills is even reaching schoolchildren – should we be concerned? **Kevin Flemen** looks at the risks and availability of alprazolam, branded as Xanax

UNDER PRESSURE

A friend of mine in Hackney was recounting a recent case involving the death of a child at her daughter's school. While the inquest results were still awaited, it appeared the death may have involved alprazolam. When I voiced some surprise at this drug being a factor, my friend said: 'All of my daughter's friends are going on about Xanax. It's really the thing at the moment.'

Xanax is the brand name of the benzodiazepine alprazolam. It is highly potent – some 20 times the strength of diazepam (Valium) – with a medium duration of effect and a half-life of around 12 hours. It is widely prescribed in America with claims that it is now the number one prescribed psychiatric medication. Most legal use in the UK is from private prescriptions as it is not prescribed on the NHS, but it is also available via the dark web.

Over the past few years, most UK reports of alprazolam have referred to it as a cut in heroin rather than a significant drug in its own right. Norwich police warned of alprazolam in heroin back in 2004, and in the more recent heroin 'drought' around 2010, reports circulated of orange-tinted heroin linked to overdoses.

Historically, the most popular benzodiazepine in the UK has been diazepam, which was frequently diverted from legitimate prescriptions. As prescribers were repeatedly reminded about the need to address widespread over-prescribing, people seeking sedation have had to resort to looking elsewhere.

Some injectors turned to temazepam, albeit with disastrous health consequences following the introduction of Gelthix capsules intended to deter injecting.

Pregabalin and gabapentin increasingly became the prescribed drugs of choice, and workers and peer educators reported an increase in 'pregabs' as a core drug of polydrug use – initially in custodial settings and then in community settings too. 'It's like sciatica is a catching condition,' commented a prison drugs worker on a training course, noting ruefully how many prisoners presented to the medical team complaining of neuropathic pain in the hope that it would result in a pregabalin prescription.

Further afield, online pharmacies represented a ready source of tablets sold as diazepam. Overseas suppliers sold it in the form of blue pills – some genuine, but others containing a range of compounds or none of the drug at all. Canny consumers became increasingly wary of purchasing diazepam from such sources.

The explosion of novel psychoactives brought with it the advent of numerous novel benzodiazepines, including phenazepam, etizolam and flubromazepam. These worked, and were cheap and widely available. Rather than seeking dwindling NHS prescriptions or chancing random blue pills from Asia, more of the depressant market turned to these NPS benzodiazepines.

So back to Xanax. Is it becoming a 'thing' in the UK? If so, why – and to what extent is this likely to become a trend?

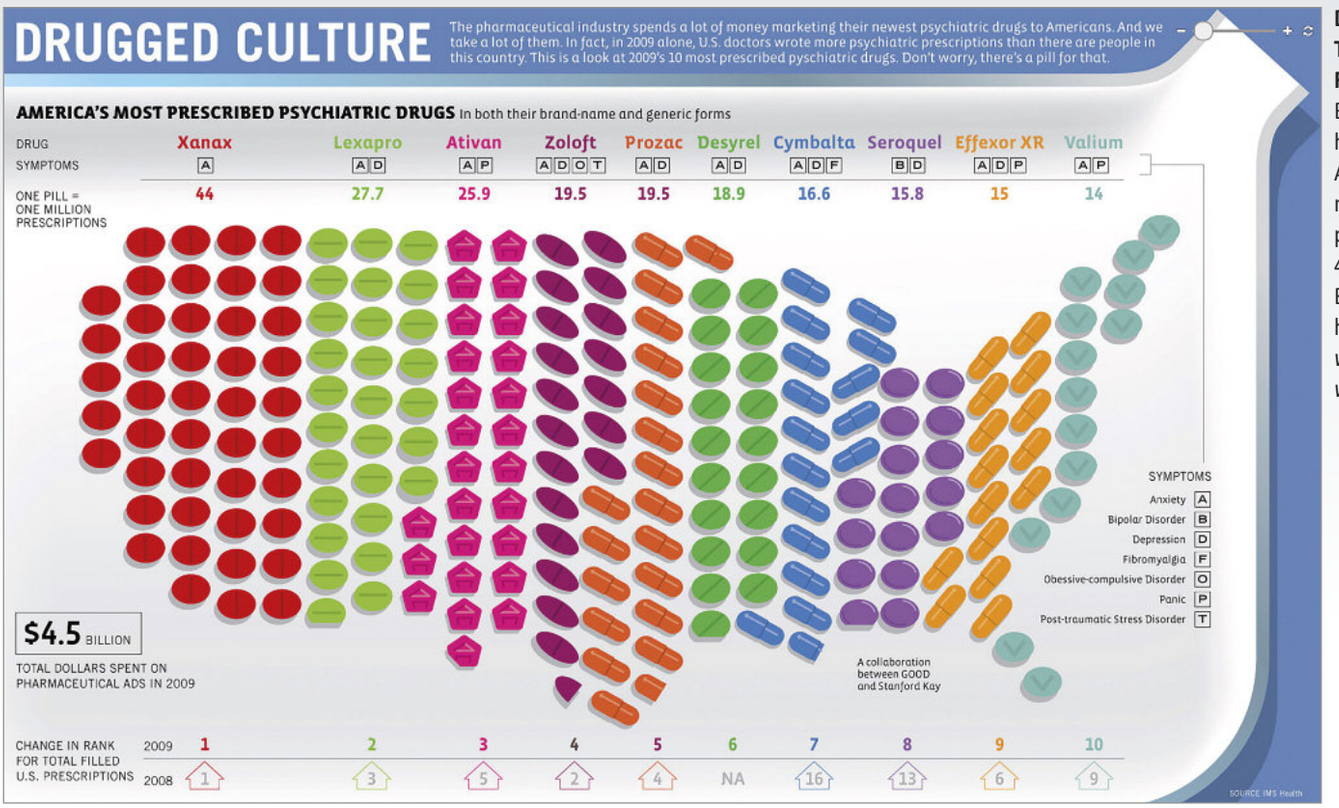
The drug has gained profile significantly. It has been linked to a number of high-profile celebrity deaths and continues to be associated with the media, earning mentions in music and film as well as appearing in many internet memes.

If diazepam is possibly a bit old and fusty, Xanax has become the sedating pill for those stressed by celebrity rather than mundanity. The school-age peers of the friend I mentioned at the start had come to Xanax via its associations with American celebrities. It was fashionable.

In recent sessions with young people in a number of settings, I've been exploring awareness of Xanax. In one (albeit small) group of young people in Norwich, all had heard of it and they mentioned memes that they had seen.

Although alprazolam isn't significantly prescribed in the UK, there's good availability via the dark web. A search filtered for European suppliers returned 297 entries on Dream Market. By comparison, diazepam returned 391 entries. Costs varied significantly, but

The drug has gained profile significantly. It has been linked to a number of high-profile celebrity deaths and continues to be associated with the media, earning mentions in music and film as well as appearing in many internet memes.



DON'T WORRY – THERE'S A PILL FOR THAT. By 2008-9, Xanax had become America's most-prescribed psychiatric drug at 44m scripts. By 2014 that figure had passed 48m. *www.good.is www.imshealth.com*

200 x 2mg tablets (the equivalent of 4 x 10mg diazepam) worked out at around £1 a tablet. There is clearly no shortage of people offering alprazolam, with the product range including raw powder and pills in various strengths.

Increased restriction on other sedating substances could further encourage its use. The existing non-regulated benzodiazepines were all automatically covered by the Psychoactive Substances Act 2016 (PSA), reducing legitimate access to these compounds via head shops and online suppliers.

The ACMD has pushed for further regulation, suggesting they be made temporary class drug order (TCDO) drugs, with a view to later making them fully controlled drugs. However, the government has declined, arguing that this would reduce the capacity to control these drugs in custodial settings. Nonetheless, it is likely that all the novel benzodiazepines will be scheduled at some point in the future.

The ACMD and government are also concerned about the diversion of prescribed medicines, and the misuse of pregabalin is a key issue. Therefore it seems increasingly likely that this, alongside gabapentin, will be made a controlled drug in the coming months. So for anyone seeking non-prescribed sedation, the dark web and illicit markets will be the main source of drugs, and alprazolam is increasingly a feature. This will be especially true for people who have built up significant tolerance to benzo-type drugs pre-PSA, and who will need to cross-substitute with similarly strong benzos to stave off withdrawal. Someone with a 2g a day flubromazolam habit would probably need 80mg of diazepam for a similar effect.

A discussion on an NPS forum made a similar point, highlighting a red 5mg alprazolam bar on the market,

> 'There are now vendors based in the UK producing their own Xanax bars for our market... there's one in particular that has just this week come out with red bars containing 5mg alprazolam...'

saying: 'There are now vendors based in the UK producing their own Xanax bars for our market... there's one in particular that has just this week come out with red bars containing 5mg alprazolam. These are pressed and sold in the UK. I do not think it is a coincidence that this is happening right after the Psychoactive Substances Act has come into force. No one with a clonazolam habit is going to get much out of diazepam after all...

'This could be the start of an interesting new trend in the UK. Alprazolam has never previously been a big thing here, but some of these UK Xanax vendors are geared up specifically to sell in bulk to dealers. I don't doubt this is a direct result of UK benzo users getting a taste of more potent benzos from the RC [research chemicals] scene. I also fully expect etizolam bars to come onto the UK market shortly, but I suspect these will be more popular given the street cred of Xanax.'

It is too soon to know if alprazolam will become a significant drug on the UK scene, but some of the key risks and issues are:

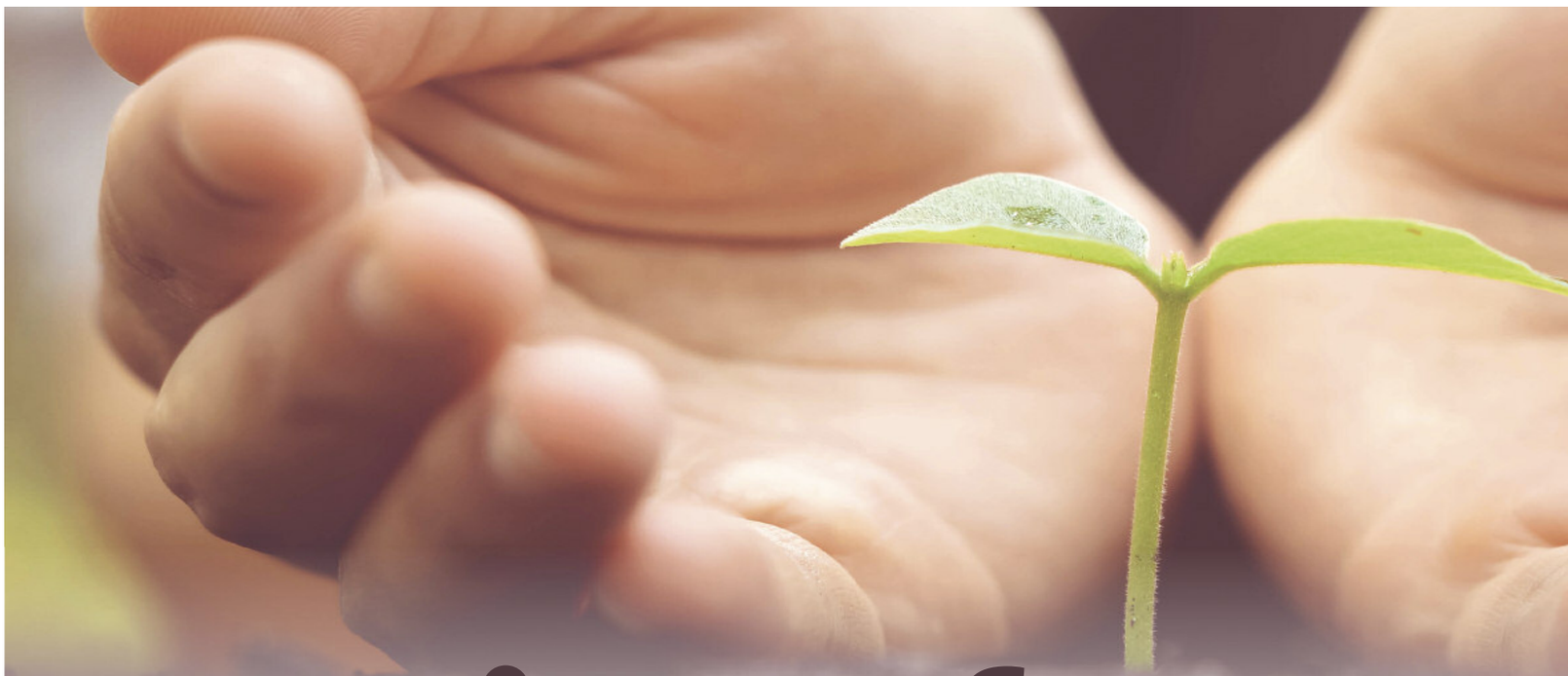
- *Alprazolam may crop up unexpectedly in compounds where it was not the sought-after drug. It may also crop up in a variety of strengths, with pills containing alprazolam ranging from 0.5mg to 5mg (equivalent of 20mg – 100mg of diazepam.) On its own this is a significant risk of overdose. This risk goes up significantly when used in combination with alcohol or opiates.*

- *If alprazolam is appealing to a younger demographic, there is likely to be a high level of ignorance in relation to risks around benzodiazepine use.*

- *As with other benzodiazepines, alprazolam can cause significant physical dependency and dangerous withdrawal symptoms. Tapered reduction may be required, including high-dose prescribing as part of a transfer from illegally sourced drugs.*

Alprazolam is certainly a significant drug – and a big problem – in America, and increasingly crops up in polydrug overdoses. From looking at its growing influence in this country, it would seem that the risks are very real.

Kevin Flemen runs the drugs education and training initiative, KFx. Visit www.kfx.org.uk for free resources.



Creating a future

Prison can be an opportunity to change deep-rooted behaviour and begin to flourish, the team at Addaction tell DDN

'I have learnt that the crime I was doing and the drugs I was taking didn't just affect me, it also affected other people – it's a ripple effect,' said a prisoner at HMP Lincoln, describing the effect Addaction's Trans4orm programme was having on him. 'It has helped me to share my problems and understand different ways to cope.'

Another participant called it 'a bright light in a dark place', and this was the intention of Louise Scherdel, Addaction's Lincolnshire Prisons service manager, when she wrote and developed the programme under the supervision of Andrew Beaver, operations manager at Grantham Community Service.

'Our ultimate goal on the Trans4orm project is to equip prisoners with strong life skills to change deep-rooted negative behaviour patterns, so they can go on to live life free from alcohol or substance misuse,' she says.

Up to 12 prisoners at a time volunteer to engage in the programme and are screened first to make sure of their commitment. Once accepted, the participants are moved from their existing prison accommodation to a small community on a self-contained 'recovery landing', where they live together for 12 weeks.

In these new surroundings – which have been refurbished and painted with bright motifs and motivational statements by Trans4orm participants – the prisoners are given intense daily therapy sessions, both individually and as a group, by Addaction's substance misuse experts assisted by peer mentors.

An important part of this programme is the Cognitive Approach to Recovery, written by Addaction to address the deep-rooted attitudes and thoughts that have resulted in negative behaviours and continuing substance misuse.

It's a 'holistic, whole-person approach', says Scherdel. 'We are always recovery-focused and work hard with the prisoners at HMP Lincoln to encourage enhanced levels of confidence, motivation and drive to achieve their own recovery... for many of the people who participate in Trans4orm it is the Addaction self-esteem, self-belief and self-confidence therapies that appear to offer them the most motivation to change negative patterns of behaviour.'

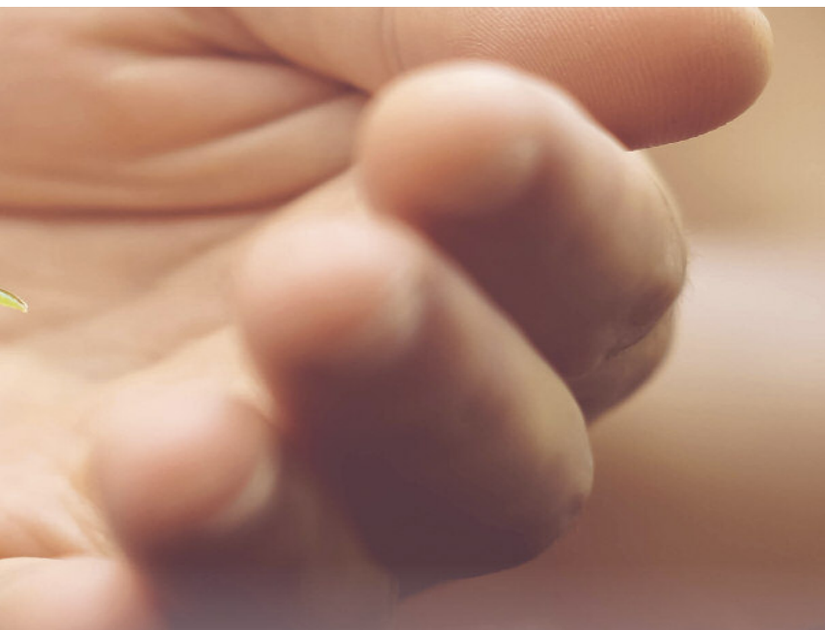
'We want people to leave prison and live a life free of drug and alcohol dependency and reoffending, and that means finding a balance between security and supportive therapy,' adds Beaver.

HMP Lincoln's governor, Peter Wright, says 'the level of need among people in Lincoln Prison is almost overwhelming', but believes the programme is making 'a profoundly important difference to the lives of the men who take part'. The 90 per cent completion rate has set a new benchmark for success.

'The best times I have here are when I meet people on the programme for their final session,' he says. 'It is a privilege to hear them tell their stories and how they have been able to face up to issues in a safe environment... Above all, I know from the moving testimony of service users that potentially life changing things are happening.'

The holistic approach to recovery includes a growing range of activities developed by the Addaction substance misuse team across both Lincolnshire prisons – HMP Lincoln and HMP North Sea Camp. Art therapy workshops have resulted in pieces by prisoners being exhibited in a London gallery; a theatre company and music therapy group are performing regularly within both prisons, and a very popular 'recovery garden' project is enabling service users to grow vegetables for homeless people and the local church.

It's all about promoting recovery as a genuine possibility – and a genuine alternative to drugs, says Scherdel. 'Keeping prisoners engaged and motivated, and helping them to reflect on their lives is very important. We want people to leave prison and live a life free of drug and alcohol dependency and reoffending, and that means finding a balance between security and supportive therapy.'



Time to reflect

I came here with an attitude, all gangster and image,
I knew I had to change my life and surely I could manage.
I said I'll go Addaction, bare my soul, but not much truth...
lip service, lie, play the system – and some crap about my youth.

I'll never tell 'em 'bout my struggles and the time I feel real pain,
Just stay under the radar, then hit the streets again.
Ha. They would never find out, I'll keep my cards close to my chest...
...Cause I'm a liar, it's my trade, at being selfish – I'm the best.

After a while though things got hard, that was never in my plan...
'Grow up' they said 'you're still a child'... I thought I was a man,
Cause I've got kids, I've a wife – and I'm way past twenty one,
I guess it's time to quit the bullshit... work has just begun.

So, now it's time to analyse my life,
The pain I caused so many and the stress I gave my wife.
Oblivious to where my life was heading,
The drugs and the crime and the women,
The court case I was dreading.

Didn't turn up 'you know'... I hid in the attic,
With the feds at my door and the dog barking erratic.
My partner knew 'to get arrested' was the only way,
But she was loyal, when they asked her where I was, she wouldn't say.

Police are in my kid's room, woken from their beds,
My babies crying 'where's my dad?' what could be going through their heads?
This is embarrassing, it's wrong... I don't do myself no favours,
How does my girlfriend feel when she sees them nosey neighbours.

Man I gotta change, and form a plan of action
Maybe I could get some help from those workers in Addaction.

Addaction peer mentor/orderly

RESOURCES CORNER

at your fingertips

Looking for the ultimate resource for research led **George Allan** to *Findings*

HANDS UP – how many of you read original research articles? Thought so! But if we are serious about basing practice and service delivery on evidence, however ambiguous and contradictory this can be, we need to know what research is telling us. Help is at hand, however: the problems of time constraints, accessing original sources and interpreting complex material are solved with *Drug and Alcohol Findings*.

Starting as a magazine, the venture became a free, web-based service a decade ago (www.findings.org.uk). Mining the largest live drug and alcohol library in the UK, Mike Ashton and associates have developed the project to include more than 1,200 documents, including:

- ***Analyses****: succinct summaries of numerous original research papers, with commentaries on their results.*
- ***Hot Topics****: explorations of controversial themes.*
- ***Review Analyses****: summaries of reviews or syntheses of research findings.*
- ***Abstracts****: outlines of research which Findings has yet to analyse.*

'In a field often dogged by believers who are prepared to fight their corners... *Findings* brings a refreshingly different approach.'

What is exceptional about the Analyses and Hot Topics is the sceptical eye which is brought to the material. In a field often dogged by believers who are prepared to fight their corners even when confronted with overwhelming evidence to the contrary, Findings brings a refreshingly different approach. In the commentaries, Mike and his associates are like dogs with bones, gnawing at the material from numerous angles in order to tease out what is important for practitioners, service managers and commissioners. If this sounds daunting, it isn't – the research is summarised in plain English and the critiques are equally accessible.

The site's search facility is subject-based for ease of navigation, but to provide ready access to essential documents relevant to particular themes, the Matrices have been developed. These are grids, one for alcohol and one for drugs, containing 25 squares. Down the side of these grids are five 'intervention types' (screening and brief intervention; generic and cross-cutting issues; medical treatment; psychosocial interventions; safeguarding the community), while across the top are five 'intervention levels' (interventions; practitioners; management/supervision; organisational functioning; treatment systems). Click on the box at the intersection of your interest and there you'll find the key documents, along with a 'Matrix Bite' describing and summarising the issues.

Being on their mailing list guarantees receiving summaries of the latest research and its implications; if you only want to subscribe to one such list, Findings is the one.

George Allan is chair of Scottish Drugs Forum and author of *Working with Substance Users: a Guide to Effective Interventions* (2014; Palgrave)

Springboard to success

RAPt's apprenticeship programme is helping people to use their experience of addiction to get back into work, as Nathan Motherwell **explains**

SINCE 2013 RAPt have been running an apprenticeship programme with a difference, and it's been quite successful. We recruit apprentices to work in our drug and alcohol treatment services across the country, helping people to address their addiction – and our apprentices are all in recovery themselves. So while helping people into work, the scheme also supports people in their own recovery.

The apprenticeship scheme is about recognising the value of people's personal experience of addiction and recovery, so we don't have any maximum age restriction. In fact, I'm quite proud to say, the average age of a RAPt apprentice is 45. RAPt managers report that apprentices provide a visible example of recovery in action, bring new energy to the teams, and offer extensive personal experience of addiction and recovery. Feedback from other RAPt staff has been that apprentices bring fresh motivation, as well as a unique energy and passion that can change the whole team dynamic in a very positive way.

Many of our apprentices have little or no work experience, and no previous experience is required. Some have been in recovery a while and are looking for a career change after working in another field, while others have voluntary experience and are looking to get their first paid job.

'We only have a 15 per cent dropout rate from the scheme and 80 per cent of all apprentices who started with us completed their apprenticeships and went on to secure further employment.'

The apprentices work towards a level 3 NVQ qualification in substance misuse or counselling. The scheme ensures that we offer significant support and learning every step of the way – all apprentices are allocated a mentor as well as a line manager. They get a wage of just under £20,000 a year for the London areas, and we also pay an allowance for external supervision and provide regular support meetings.

A lot of our apprenticeships are based within prisons in London, Kent, Norfolk, Surrey and Sussex. One of the challenges has been getting people with criminal convictions the security clearance to work in the prison system. We have also offered a large number of apprenticeships within our community projects and administration roles at our head office.

The results of the scheme are amazing, especially considering the challenging nature of working inside prisons. In the last three years we have offered more than 80 recovering addicts and alcoholics apprenticeship placements at RAPt. We only have a 15 per cent dropout rate from the scheme and 80 per cent of all apprentices who started with us completed their apprenticeships and went on to secure further employment. Many of them have moved on and are now working for other service providers, as well as many being employed permanently with us at RAPt.

With the new government apprenticeship levy coming into force this month, funding could become available for apprentices of all ages. We are hoping this could enable RAPt to expand the scheme and roll out our apprentice programme to other service providers.

Nathan Motherwell is RAPt apprenticeship co-ordinator and a former RAPt client in recovery

'THEIR FAITH IN ME WAS PRICELESS'

Former RAPt apprentice Gary Broadway shares how the scheme started his career

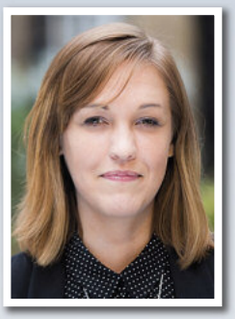
I HAD MY LAST DRINK IN 1995 and I've been sober ever since. When I found out about the RAPt apprentice scheme, it seemed like the ideal next step for me.

My role as a drug and alcohol practitioner apprentice involved a huge variety of things, from admin to working with clients. I went to college as part of the scheme, gaining NVQ levels 2 and 3 in counselling. RAPt were great and made sure that I got the help I needed.

'My favourite thing was working with challenging clients and seeing the difference in them, as well as learning new skills. I'd never used a computer before I started, but soon learnt to use one to write reports. My confidence grew so much, as well as my skills. When a job as an alcohol worker came up, I decided to go for it and I got it.

'To be given a chance to be an apprentice is an honour and I'm eternally grateful. RAPt had faith in me and that feeling is priceless. It's wonderful to be able to tell my kids about what I'm doing – they're so proud of me. I would tell anyone to have a go at the apprenticeship. It has been an amazing chance and has shown me I can now have a career in a job I love.

More legal advice at:
www.drinkanddrugsnews.com



A challenging relationship

While maintaining a productive relationship with CQC is essential, so is challenging any worrying issues on their draft reports, says **Nicole Ridgwell**

Over the past year, one topic is a regular feature when substance misuse providers meet at conferences, at training events, and in the waiting rooms of law firms; that their CQC inspection reports are peppered with negative commentary. This commentary, according to providers, does not address their core services but the more tangential and arguably minor aspects of their services. Frustratingly for providers, these critical reports appear to disregard clear evidence of statistically positive outcomes being achieved by the service in question.

The reputational and financial damage caused by such negative reporting is leading some to reflect on whether they are able to sustain services in a sector whose regulator appears to be at war with it.

This fear of being 'regulated out of the sector' is also being reported to us at Ridouts. The concern is that CQC has a fundamental misunderstanding of the services they are now regulating. As previously covered within this section, some of the uncertainty of this inspection cycle arises because it has been the first under the new inspections regime. Indeed, by declining to publish ratings during the first year, CQC tacitly acknowledged that this set of inspections was a trial run. However, providers are worried that their experiences indicate more than the initial hurdles of a newly implemented system; there is a disquieting suspicion that CQC inherently distrusts the motives of the substance misuse sector.

The CQC press release of September 2014, setting out the planned changes to the inspection regime, acknowledged that *'substance misuse treatment is a unique, diverse sector and people using these services often have complex and varied needs'*. However, it is this very complexity and the corresponding diversity of treatments used which has been at the core of much of the criticism directed at providers.

As with other sectors brought into regulatory regimes, it may take time for the sector and its regulator to understand each other. I would argue that this only strengthens the need for both sides to engage at every opportunity.

Providers may hesitate to challenge an allegation of regulatory breach even in situations where the thing they are being criticised for is at the heart of the care they provide. A common example of this is where the treatment regime is not that recommended within the NICE guidelines. In my experience, it is not that providers were unaware of the guidelines, nor that they had a 'devil may care' attitude to compliance, but that they and their experts had thought long and hard about the nature and experiences of their service user group and concluded that an alternative care pathway was required.

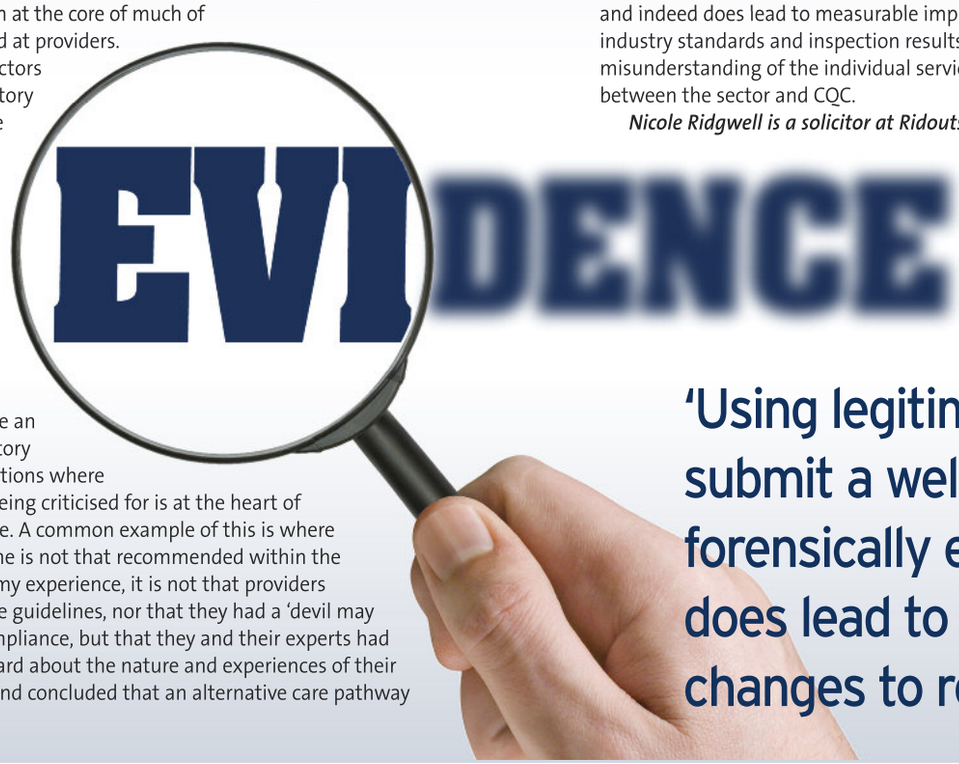
This returns us to the importance of an outcomes-based inspection process and the corresponding need to challenge CQC's assumptions. If CQC's chief inspector of hospitals, Professor Sir Mike Richards, meant what he said in his September 2014 press release – that *'it is vital when looking at substance misuse services that the views, opinions and experiences of people who use them are listened to and that any judgement that we make about those services reflects what we have heard'* – then service user outcomes must be central to all inspections.

It is understandable that providers feeling under siege may hesitate to object, for fear that CQC inspectors would return with a grudge. Yet, not only is there a separate and well-worn complaints process to tackle such blatant prejudice but the advantages of challenging through the factual accuracy process are two-fold: for the service, using legitimate routes to submit a well-drafted and forensically evidenced appeal does lead to substantive changes to reports; for the sector, a cogent explanation of a service's rationale helps CQC to better understand the sector as a whole.

The impact of challenging draft reports will become even more stark from this month; April 2017 is identified within the *CQC strategy 2016–2021* as the month CQC intends to introduce ratings to the substance misuse sector. As any CQC-rated service understands, the blunt headline description of a service as 'inadequate' or 'requires improvement' will turn away far more private referrers and local commissioners than reading the more nuanced contents of the actual CQC report balancing the good with the bad.

It is therefore vital that providers scrutinise their draft reports and challenge where they fundamentally disagree. Productive interaction with the regulator can and indeed does lead to measurable improvements in outcomes both in terms of industry standards and inspection results. To do otherwise is to allow public misunderstanding of the individual service, whilst perpetuating the mistrust between the sector and CQC.

Nicole Ridgwell is a solicitor at Ridouts LLP, www.ridout-law.com



'Using legitimate routes to submit a well-drafted and forensically evidenced appeal does lead to substantive changes to reports.'

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MONDAY 1st May

ORIGINS

9.30AM - 11.00AM PRESENTED BY DR NEIL BRENER
ADDICTION & THEATRE THE SEARCH FOR THE "TO BE OR NOT TO BE "CENTRE"

11.30AM - 1.00PM PRESENTED BY PROFESSOR PHILIP JAMES AND DR FRANK LAWLIS
OXYGEN AND BRAIN PLASTICITY

2.00PM - 3.30PM PRESENTED BY DR MARIA KELLY AND PROFESSOR JONATHAN CHICK
SYMPOSIUM ON PRESCRIBED DRUG MISUSE AND ADDICTIONS TREATMENT

4.00PM - 5.30PM PRESENTED BY DR ALBERTO PERTUSA
OCD, HOARDING DISORDER AND BDD: A PRACTICAL UPDATE

TUESDAY 2nd May

9.30AM - 11.00AM PRESENTED BY DR OWEN BOWDEN-JONES, DR DIMA ABDULRAHIM AND NEIL DICKENS
DRUG USE IN A SEXUAL CONTEXT; THE CASE OF NOVEL PSYCHOACTIVE DRUG USE BY MEN WHO HAVE SEX WITH MEN

11.30AM - 1.00PM PRESENTED BY DR MARK GRIFFITHS AND JACKY POWER
THE SNS PARADOX: EXPLORING HOW SOCIAL NETWORKING SITES CAN BRING USERS BOTH A SENSE OF CONNECTION AND DISCONNECTION

2.00PM - 3.30PM PRESENTED BY PROFESSOR KIM WOLFF
DRUG TESTING EXPLAINED: WHAT, WHY AND WHEN

WEDNESDAY 3rd May

11.30AM - 1.00PM PANEL PRESENTED BY DR GLYNIS READ, DR LEIGH NEAL AND ADELA CAMPBELL
21ST CENTURY INTEGRATIVE TREATMENTS GROW IN EVIDENCE AND EFFECTIVENESS

2.00PM - 3.30PM PRESENTED BY DR RICHARD SHERRY
BURNOUT AND STRESS

2.00PM - 3.30PM PRESENTED BY DR SHRUTHI GURUSWAMY
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09.30AM – 11.00AM GLOBAL FREEDOM

PANELISTS

Tamara Barnett, Andrew Wallis and **Kathleen O'Hara**






11.30AM – 13.00PM - THE CRISIS OF CREDIBILITY IN ADDICTION TREATMENT: AND WHAT CONSTITUTES CREDIBILITY ANYWAY?

PANELISTS

John Trolan, DR Bob Lynn, Abigail Cooper and **Tim Leighton**

14.00PM – 15.30PM RECOVERY ORIENTED TREATMENT SYSTEMS – IN POLICY AND PRACTICE

PANELISTS

Mike Trace (Chairman), **Noreen Oliver** (UK), **Raymond V. Tamasi** (USA) and **DR Elif Mutlu** (Turkey)






16.00PM - 17.30PM - GLOBAL INTEGRATION: THE NEED TODAY FOR STANDALONE ADDICTION SERVICES TO STRATEGIZE BEYOND THEIR EXISTING ACTIVITIES, CONSIDERING SOLUTIONS TOWARDS SUSTAINABILITY.

PANELISTS: **Raymond V. Tamasi, DR Kostas Agath** and **Gail Jones**

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MORE CHOICE...

It hasn't always been the case, but opioid substitution therapy is now accepted as a key instrument in enabling recovery. Having got this far – and despite the ever-present threat of cuts – is improving choice the next key step, asks DDN

Although divisions inevitably still exist, and probably always will, we've come a long way since the sector was polarised by those bitter harm reduction versus abstinence arguments, with concerns over budget reductions and the austerity agenda perhaps helping to focus minds on the bigger picture.

A significant step on this journey was the NTA's 2012 *Medications in recovery* report (DDN, August 2012, page 5), which has come to be seen as a landmark document. A fundamental re-examining of the treatment methods and objectives that can lead to recovery, it concluded that while 'entering and staying in treatment' and 'coming off opioid substitution treatment' (OST) were undoubtedly important indicators, they did not constitute recovery 'in themselves'.

Delivered properly, OST had 'an important and legitimate place within recovery', providing as it did a platform of 'stability and safety that protects people and creates the time and space for them to move forward,' it stated.

What was also vital, it stressed, was to focus on broader support and make sure that OST is always delivered in line with clinical guidance.

Shortly after the report's publication, Professor Oscar D'Agnone – at the time clinical director of CRI, and now medical director of London's OAD Clinic – wrote a *DDN* article expressing hope that the report might help put an end to the false dichotomy between abstinence and prescribing and bring about a situation where services would simply choose what worked best from a range of interventions (*DDN*, September 2012, page 23).

Nearly five years on, he feels it 'was positive to move from a strategy based only on harm minimisation to a recovery-focused one that included harm minimisation,' but that the creation of that ideal treatment landscape has been hampered by budget cuts. 'Over the last couple of years we've been witnessing massive reductions in treatment budgets, which has had massive implications for treatment and implementing recovery strategies,' he says. 'I think the recent rise in death rates we're seeing is probably related to these policies, and not just to aging populations.' Those groups are simply the most vulnerable to these policies, he believes. 'You have a lot of people over 55 or 60 who have been on prescriptions for years and they have been removed from those prescriptions for reasons that I don't think are related to the recovery agenda, but to budget reasons.'

Indeed, the *Medications in recovery* report concluded that, while people should not be 'parked indefinitely' on substitute drugs – and that all prescriptions should be regularly reviewed – neither should arbitrary time limits be imposed. Is the sector more accepting of that position now? 'Well, I think those statements are made from Mount Olympus, if you like – people on the ground are seeing different things,' he states. 'In my clinic, I have 48 people over 60 and eight people over 70. You can argue that these people should not be on high methadone or other prescriptions, whether that's right or wrong, but what I'm saying is these people are alive and kicking and I'll keep them on the same dosage. If I impose a reduction on them, they'll start dying. And that's what we're seeing in the north west of England and other areas.'

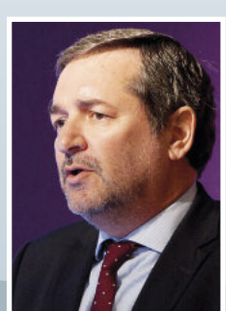
It's argued that time limiting OST not only threatens people's ability to sustain their recovery but also risks increasing blood-borne virus transmissions, drug-related deaths and more. Would he go along with that? 'Absolutely,' he says. 'It's for the patient to say when the time has come to stop, not for me to impose that. The problem is that a heroin user nowadays is an old adult – they've been on heroin for a long time. Setting time limits for these patients is very, very risky. All these considerations about time limitations are based, basically, on budget reasons, not clinical reasons. There's not a shred of evidence that time limiting will produce better outcomes.'

Ultimately, choice is vital when it comes to prescribing, he believes. 'At my clinic I have patients coming from the public sector and the private sector, and we have a more open-minded view – they have more freedom to discuss the medications they'd like to take, and the doses. I'm receiving people who are on 1.5mg of buprenorphine, and all they wanted to be is on 2mg, but they've been told, "no, you have to be on 1.5, and reducing". That's ridiculous, and it's putting people at risk.'

As part of the quest to respond to patient need, new versions of drugs are constantly being developed and trialled, including injections of naltrexone and buprenorphine that can last up to six months, as well as a rapidly dissolving buprenorphine wafer, now approved in the UK as Espranor. As standard

'Setting time limits... is very, very risky. All these considerations about time limitations are based, basically, on budget reasons, not clinical reasons. There's not a shred of evidence that time limiting will produce better outcomes.'

PROFESSOR OSCAR D'AGNONE



More on patient choice at
www.drinkanddrugsnews.com

MORE OPTIONS

buprenorphine capsules can take between five and ten minutes to dissolve – clearly far from ideal for supervised consumption in a busy pharmacy or prison setting – it's hoped that products like this can help cut the drop-out rates for buprenorphine treatment, which currently stand at about 50 per cent within six months.

'We're finding administering Espranor takes about 30 seconds, so it's certainly a much quicker product than the generic hard compressed tablet,' says GP and substance misuse specialist Dr Bernadette Hard, who has been prescribing Espranor in her Cardiff-based service since January. While her service began using it in a criminal justice setting, they have since had some clients move their prescriptions to community pharmacies, she points out.

'Our main motivation for wanting to trial this new preparation was the challenges we faced around diversion and misuse, and we had around 30 people when we did the initial switch,' she says. 'The people that we felt were appropriately on buprenorphine and benefitting from it had a very positive experience with switching – they liked the fact that it dissolved quicker and they didn't feel they were being scrutinised, because if you are taking it properly but someone feels you might not be, that can be quite uncomfortable. Some pharmacists are really good and respectful, others less so.'

The feedback so far has been very positive, she says. 'For those clients where we were always a little bit suspicious around their motivation for wanting to be on buprenorphine, some of them did struggle with the switch. Some found that – where they probably hadn't been taking their full amount before – when we switched them onto Espranor they had to reduce their dose because they were finding it a little too strong. One or two have actually said they used to get bullied for their tablets, so they'd prefer to be on Espranor because they have fewer people requesting them, things like that.'

So how important is choice in substitute prescribing generally? 'Well, we don't have many options,' she says. 'You can try and categorise via a patient's history who you think is going to do better on methadone or buprenorphine, and most of the time we're right about that. But not always, and some people just gel with one product and I think it's important that we respect that, in the same way we would in primary care. It's part of building a mutual relationship, where you're not just dictating to them.'

At the recent *DDN* service user conference, however, it was pointed out by user involvement activists that this is perhaps the only medical area where people don't always have those conversations about choice with their doctors (*DDN*, March, page 8). It can often be a case of 'here you go, I'm giving you this'.

'I would challenge that, actually,' she says. 'There are areas where we can sound quite paternalistic and also where we're being driven by budget, but that's not exclusive to substance misuse. I think it can sometimes feel that way in substance misuse because an awful lot of the way we deliver services is by its very nature paternalistic – because we're supervising people and so on.

'But I think more choice and more options is always going to be beneficial, and we have to get in there and use these things,' she states. 'I've been on development groups and the like, and we can all sit around as experts and ponder how this is going to pan out and where it's going to be of most use, but sometimes you just need to use it – obviously in controlled way – to really understand where people are going to go with it.'

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

PRISON PERSPECTIVES

A first-person account of nearly a decade at the frontline of prison substance misuse services

Last year I resigned from my position as a service manager due to burnout, having spent the last two years fighting to offer the best level of treatment and support to the clients we had in our care. I am a resilient individual but the experiences I encountered made it impossible for me to continue in my role as I felt my personal and professional integrity were being compromised.

Now, having had time to reflect, I am finally in a place to share my experiences. Furthermore, I feel compelled to share what I feel is a poor level of care offered to clients in prisons. This substandard level of care changed very little over my time working within the service.

I started working in addiction services because I felt I could make a difference. A great deal of the frontline staff that I worked alongside, and then managed, had the same belief. These staff maintained their dedication and commitment to the clients even though they were directed to work with programmes and models of treatment they knew were not best practice. We knew that we could offer more and do more but were prevented from doing so.

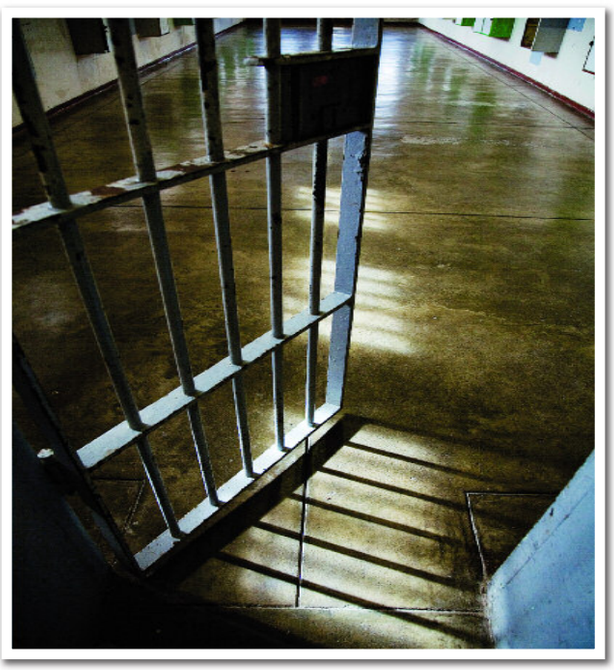
I have seen some of the best and worst practice in my time with the service, including the dismissive and unethical ethos of some managerial staff regarding clients in their care. I worked in a unit where every year it was common practice that clients would be rushed through a very intense treatment programme in less that the minimum time, so the yearly targets could be met. This demonstrated a real lack of care for clients and a compromise of good treatment practice.

I took on the role as service manager so that I could make sure such bad and unethical practices could no longer take place, and with the support of my line manager – who was amazing – I introduced a new programme that was open to all clients engaged in the service. This included holistic interventions such as Tai Chi, mindfulness, yoga and animal therapy. I established a recovery wing and integrated clinical and psychosocial services, and as a result more clients engaged with the service, referrals to rehabs increased, and the number of clients on methadone scripts declined by over 50 per cent.

Despite the improvements, I felt there was more we could do but it required the support of the organisation that I worked for, and its ability to adapt and grow. However the resistance was constant, even though the positive changes that we had already made demonstrated good results and a better level of care and treatment for the clients. The pressure from the organisation was immense, with increased audits, visits, meetings and constant questioning, and without acknowledgement or recognition that positive change was occurring. Slowly the organisation fragmented the integrated service that I was successfully running and improving. I was no longer allowed to manage the whole service, and clinical services were re-allocated to another manager. As a result, this served only to withdraw the single point-of-service contact for the client, and, ultimately, the number of clients receiving prescribed medication began to increase once more. Any data collected led to little or no change in practices, and there is now no single point of contact for the client due to ineffective management and a separation of clinical and psychosocial treatment, leaving the client unsure who is taking the lead in their care.

I would like to add that prisons are very difficult places to work and over the past seven years they have suffered dramatically due to well-publicised funding cuts. It would also be easy to say 'why should we care about these clients?' Yet those of us who have worked with them know how valuable the work and the clients are, and that most have suffered mental and physical abuse, are from deprived upbringings – often growing up in the care system – and have fallen through the cracks in society. Nevertheless, they can and do change, addiction can be effectively treated, and these clients can go on to live happy and productive lives. But we cannot do that without change. We need organisations that are prepared to evolve, accept change, become innovative and creative, and listen to the caseworkers and the clients. Without this, the level of care will continue to decline and clients will continue to suffer.

I believe that for a short period of time I scratched the surface of what could be achieved, and saw the real tangible effects for clients. I sincerely hope that change will come soon and, as we approach the next round of tendering, the 'same-old, same-old' does not prevail.



'I feel compelled to share what I feel is a poor level of care offered to clients in prisons. This substandard level of care changed very little over my time working within the service.'

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN at the address on page 3. Letters may be edited for space or clarity.

'While headlines and media discussion report numbers and systems, we need to focus on individuals.'

DEADLY SERIOUS

I enjoyed both attending the recent *DDN* national service user involvement conference, and reading the coverage in the latest issue of the magazine. Meeting and networking with some fantastic projects from around the country really opens your eyes to the innovative work that is going on, especially in the face of reduced resources.

However the one element of the event that made the most impact on me was the session around drug-related deaths, which engaged with the audience and asked for their personal experiences. The session highlighted that while headlines and media discussion reported numbers and systems, we needed to focus on individuals and the human tragedy being created. Though there may be multiple reasons for the increase in drug related deaths, including access to treatment, social deprivation, and wider health care issues such as hepatitis C, one that delegates kept returning to was stigmatisation and how drug users are often viewed to 'have brought it on themselves'.

Unfortunately while we can't wave a magic wand to increase funding levels and improve treatment for all, challenging stigma and highlighting the human tragedy of addiction and in particular drug-related deaths is something that can be done. There are some fantastic campaigns that do this such as 'Support Don't Punish' and the Remembrance Day events in July, but I would be keen to hear of any more projects or initiatives that local groups like ours can get involved in.

John Matthews, by email

If you are involved in any campaigns that challenge stigma, please let us know.

BE A KNOCKOUT!

We are gearing up for our fourth annual recovery games for the Yorkshire and Humber region and are looking for ways to support the event.

We usually host it at a local water park near Doncaster and it is an ideal opportunity for groups of individuals to come and participate, as well as family, friends and children. The event is based around *It's a Knockout*, with groups of approximately ten taking part in trials throughout the day, with a final obstacle course race to decide the winning team.

Year on year we have seen more than 400 people attend and last year over 600 people joined us and took part in our fantastic 'colour run' and games.

This year we are keen to invite other organisations to help support the games, as they are a fantastic opportunity to celebrate visible recovery and tie into the 'five ways to wellbeing'.

If you are interested in sponsoring this event, or are able to contribute in any way, please contact me on 01302 303902 or Stuart.Green@rdash.nhs.uk.

Stuart Green, service manager, Aspire

MEDIA SAVVY

The news, and the skews, in the national media

RISE OF THE ZOMBIES: Cheaper and more addictive than crack, Spice is the synthetic drug that turns users into the 'living dead' in minutes and is ruining lives across Britain.
***Mail* headline, 10 March**

'ZOMBIE' DRUG side effects to be recorded on national database.
***Telegraph* headline, 22 March**

DEAD MEN AND WOMEN were walking the streets of central Manchester this week. Some of them, their faces wan and eyes open but filled with a terrible vacancy, stumble forward with arms out-stretched. Others stand stock-still like shop mannequins, seemingly unconscious but upright, or slumped forward, as commuters scurry past with their heads down... These are the victims of Spice
Andrew Malone, *Mail*, 10 March

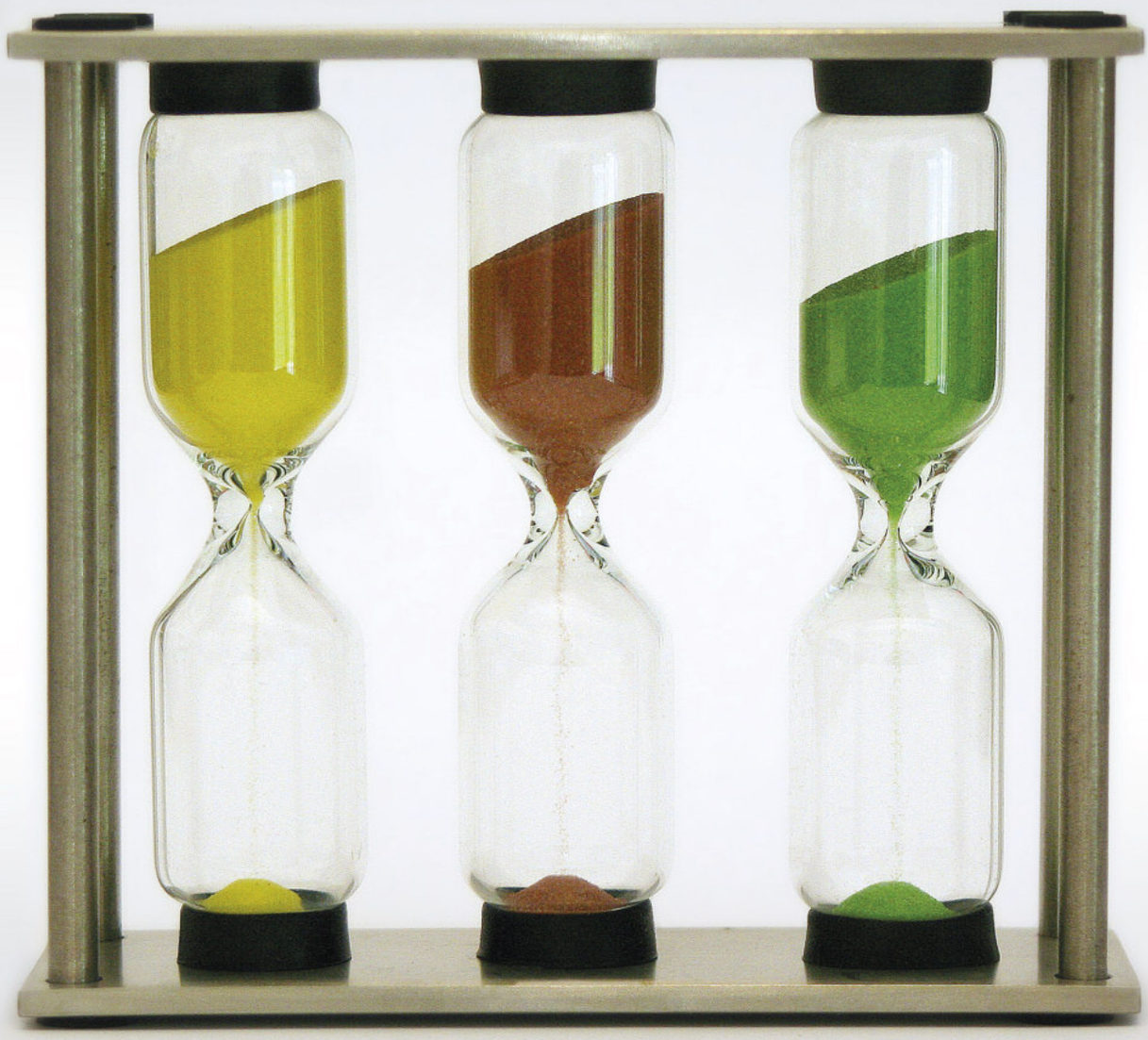
HEROIN ABUSE is a subject surrounded by horror and myth, frequently exaggerated and increasingly viewed by medical opinion – and the courts – as a sickness rather than wrongdoing. What is not in doubt is that this drug often does grave damage to those who take it, and that some of them pay for their habit through vicious, selfish crime, in some cases against friends and family... It costs UK taxpayers an estimated £300m a year to provide methadone, but very few who take it, perhaps 5 per cent, abandon their habit. They might have done so anyway.
***Mail on Sunday* editorial, 5 March**

THE WESTMINSTER KILLER was another lowlife jailbird, who had been in prison three times for (among other things) stabbing a man in the face... A former school friend says he began to go downhill after he started smoking cannabis in his teens. Even if he gave up later, cannabis is linked to long-term, lingering mental illness. He is also said by some who knew him to have been a bodybuilder, so he may have been taking steroids – these powerful mood-influencing drugs were also used by the Norwegian mass-murderer Anders Breivik, the rampage killer Raoul Moat, and the Orlando mass-killer Omar Mateen. I doubt we'll ever know, since the authorities, obsessed with finding links to a bearded supremo in an eastern cave, are almost totally uninterested in the amazingly strong correlation between mind-altering drugs and crazed violence, and so don't find out.
Peter Hitchens, *Mail on Sunday*, 27 March

ALL TOO MANY ARE IN PRISON because of our failed, woefully misguided 'war on drugs': not just the possession and distribution of arbitrarily criminalised substances, but other crimes linked to the trade. Black Britons are far more likely to be stopped and searched on suspicion of possession, and far more likely to be charged and incarcerated if they are found with drugs. Lots of well-to-do white youngsters experiment with drugs at some point, but are unlikely to suffer a sanction with life-changing consequences.
Owen Jones, *Guardian*, 7 March

TIME TO TALK

Talking therapies are among the many options that should be offered alongside OST, says **Clive Hallam**



The best treatment system provides a spectrum of interventions for those wishing to explore them. While we live in a time of 'austerity' there has to be sufficient funding in the system... There isn't one size that fits all.

Recently, a post on social media considered the question of whether talking therapies added any value to people who were committed to opioid substitution treatment (OST) on a long-term basis.

National data shows the group of long-term, committed recipients of OST is growing, month on month, across the country. However it isn't clear whether this is because of a personal desire for, and commitment to, long-term OST, or because people have been stranded on repeat prescriptions, with minimal contact from a practitioner – both conditions exist.

Certainly, the figures correspond with cohorts of individuals who have long careers of substance use and are highly complex, and this brings into question the ability of current treatment delivery to respond appropriately.

People may commit to long-term, or lifetime, treatment for a variety of reasons, objective and subjective. There may be a clear clinical need in certain cases; however, people also resist change and avoid challenge.

Pharmacological interventions are comparatively well researched and evidenced, with the effects quite easy to predict and observe. Therapeutic doses can also be achieved relatively quickly, enabling an individual's physical circumstances to be moderated effectively. But the effect of those doses may be more than we envisaged in terms of affecting someone's ability to interact, and some researchers have linked methadone with significant cognitive impairment.

By comparison, talking therapies depend almost exclusively on the specific relationship between the person and the practitioner to be effective – the emotional context and connection, and a desire to respond or change dynamically.

NICE considers that few talking therapies have the evidence base to warrant their use, particularly in this client group, preferring contingency management to support people in OST. But if a person's ability to reason is adversely affected by opiate use, might this be the primary reason for the failure of talking therapies – and should this be factored into decisions about treatment?

Other issues also come into play here. At what point has the impact on the individual been measured? How resistant is the person to talking? Do they regularly miss appointments believing they won't benefit from them? Do they present on the autistic spectrum? Can they get their prescription and side-step psychosocial altogether? All these questions are as relevant for the long-term methadone patient as for the person just starting treatment, and make the success of talking therapies difficult to qualify.

What could be of more importance is a person's access to meaningful use of time, whether to pursue hobbies, learning, look for volunteering or work opportunities, or otherwise be diverted from their established courses of action and interaction. There is a clear role here for mutual aid, residential rehabilitation and therapeutic communities – yet aren't these types of talking therapies?

Nicholas Christakis (*Connected*, Harper Press, 2009) speaks of changing people's outlooks and cultural position. He argues that individuals in a concentrated network naturally exhibit its predominant emotions, actions and cultural perspectives. To effect positive and sustainable change, exposure to 'integrated' networks, with a range of views and cultural stances is necessary. Mutual aid and recovery communities are excellent gateways to such networks; concepts such as time-banking and co-production enable individuals to explore their aspirations, skills and knowledge. This is supported by the observations of William L White in the United States.

Experience across the country has demonstrated the value of running such programmes side by side, enthusing people to be involved in activities such as equine therapy, working in the countryside, and time-banking with local communities, at the same time as receiving OST.

Fundamental to this approach has been psychosocial support, providing an opportunity to discuss issues, events and concerns in an encouraging, supporting and enabling environment. Keyworkers and psychosocial practitioners can have a crucial role to play in enabling individuals to experience and understand their worth in such environments.

Any viable system must offer a range of interventions that present the most options for pursuing a full life. If this isn't also given to lifetime methadone patients, including the option to stop OST, how can they make an informed judgement?

During my career as a commissioner, I've resisted the concept of tendering every few years to find the 'best response', the 'most economically advantageous tender' and the 'best provider' for the task. Treatment provision is fundamentally different to purchasing stationery and, while there's a place for market testing, it can be detrimental to long-term care and outcomes that celebrate the best in individuals.

Commissioning is an art form, working with people in treatment, families and communities, providers and partners to ensure maximum opportunities are identified, explored and delivered. It is about seeking solutions that are sometimes the best, sometimes wrong, often pragmatic, but always looking to offer individuals the chance to choose something that is right for them. That may be a lifetime prescription – equally, it may be a detox through a personal realisation after years that there's something more to life. We shouldn't define either aspiration, or delivery, by saying one way or another is the only way.

The best treatment system provides a spectrum of interventions for those wishing to explore them. While we live in a time of 'austerity' there has to be sufficient funding in the system to adequately care for people through prevention, harm reduction, early intervention, structured community and residential interventions and aftercare – and, underlying it all, mutual aid and positive social networking. The question should be, how do we employ all interventions in a way that enables individuals to achieve their highest potential, benefiting themselves and those around them. There isn't one size that fits all.

Our current system of drug treatment, begun under the tenets of harm reduction, remains predicated on the criminal justice arguments of the early 2000s, which unfortunately hides the more relevant harm reduction message. People do not need to be placed on methadone for life and until this argument changes, options for recovery will remain limited, with interventions responding in part only to the needs of the individual.

The narrow argument concerning what is right for individuals needs to be consigned to history. Individuals, commissioners and providers must move to one that liberates individuals to make the decisions that are right for them – governed by facts, aided by considered support, and revelling in aspiration and recovery. There are many routes to recovery; as many as there are people who need them.

Clive Hallam has worked in the sector for 13 years as a commissioner and consultant

More about hepatitis C at:
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STUCK in the system

New treatment for hepatitis C has opened up massive opportunity for all-round health gains that we are just not taking, hears DDN

We need to look at syndemics, said Charles Gore – when a set of linked health problems such as hepatitis C, drug and alcohol issues, mental health and homelessness interact to increase the person's poor state of health and chances of disease. As chief executive of the Hepatitis C Trust and vice chair of the Hepatitis C Coalition, Gore was speaking to the Drugs, Alcohol and Justice Cross-Party Parliamentary Group about access to treatment.

In Scotland, treating people who injected drugs for hepatitis C had reduced death rates for this group by 50 per cent – 'so treating hepatitis C might be a way of breaking this syndemic apart', he said.

People who were treated were more motivated to address other factors, he explained, 'so hep C treatment has a bigger effect than you might think'.

There had been 'great breakthroughs' in hep C drugs, which had a 95 per cent cure rate and were very tolerable to take (compared to previous treatment, which took a year and was 'very unpleasant') – 'so we're in a new era here', he said.

In England there were around 160,000 people with hepatitis C, but a budget to treat only 10,000 of them. Treating all of them, at a cost of around £200m, would be 'a lot of money – but not compared to other disease areas'.

The first year of new drugs had seen an 11 per cent decrease in mortality and a 50 per cent decrease in demand for liver transplants. 'The gains in terms of health are enormous,' said Gore.

The reasonably short course of eight to 12 weeks for the new treatment also meant there could be a big impact on treating people in prison.

Despite this, hep C testing and treatment levels in prison were low and prevention strategies 'quite muddled and not homogenous across the prison estate', failing to tackle the common transmission routes of shared needles, tattooing and sex.

In the community, there were wide variations in treatment strategy throughout the UK. In Wales, health boards had put money aside but could not find enough people to treat, while in England, a cap on numbers was stopping many people from accessing treatment. 'Some areas of the country have massive waiting lists, but some are running out of people,' said Gore. Financial incentives for finding and following up people after treatment also risked making low priority cases of those who were hard to follow up – *ie* the drug-using population.

The NHS was investigating procurement deals with pharmacies, and Gore explained that the Hepatitis C Trust had a preferred model of 'one price for an unlimited amount of treatments, so there would be a great incentive to treat as many people as possible. At the moment, the system disincentivises treatment and the cap disincentivises testing.'

Treating the prison population represented a 'huge opportunity', Gore believed – 'It's one area where you could send people out of prison better than they went in.' There were 10,000 people in prison with hepatitis C, and 'if we took this population and treated them we could make a big difference'.

The current cap and rationing system did not prevent members of the population with advanced liver disease from being treated as a priority. The problem was for those who had to wait two years – 'and this assumes you're in services,' he explained. 'But you may be in prison. You may be a person who might not be in touch with services again, and when you do, you may have liver cancer.' Prison might be the only chance you have to treat them, so we were missing a significant public health opportunity, he said.

Gore also underlined 'the tremendous importance' of linking with people who are released from prison, who might be part way through treatment. 'If we concentrated on prisoners' health, we would have a much better chance of improving their chances.'

The parliamentary group's discussion reflected PHE and NHS England's need to work together on a hep C prevention strategy, but there was concern that 'fragmented commissioning' was hampering efforts, with costs falling in different parts of the system and no 'strategic flow' between them.

'There's a lot of joining up to do,' said Gore. 'People who spend and people who gain are different people.'

The first year of new drugs has seen an 11 per cent decrease in mortality and a 50 per cent decrease in demand for liver transplants. 'The gains in terms of health are enormous.'

CHARLES GORE

Kaleidoscope Project
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With their roots in harm reduction services, Kaleidoscope Project provide both community and residential drug and alcohol treatment. Their new 20-bed detoxification unit in Merseyside continues their tradition of providing life-changing support for every individual.

REFLECTION OF HOPE

'For the last 49 years Kaleidoscope has worked with some of the most marginalised clients with the highest need,' explains chief executive Martin Blakebrough. So when the opportunity came up to incorporate Arch Initiatives into the Kaleidoscope family and add to the residential detox facilities at Birchwood House, it seemed a logical step for the organisation.

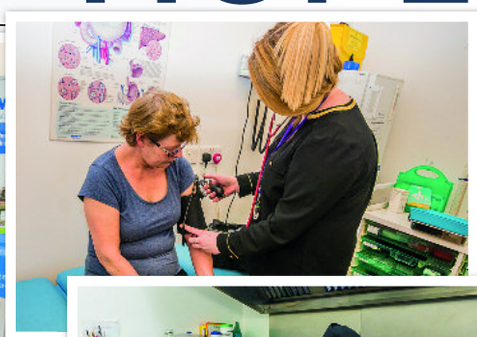
The move was never part of an attempt to become 'the next big player', Blakebrough emphasises, but rather a natural progression for Kaleidoscope. 'Running Birchwood provides a chance to develop a bespoke inpatient treatment facility. A place that can support a broad range of clients, including those with complex needs.'

To achieve this, it was important to have the right team in place, which Blakebrough is confident about. 'In Kaleidoscope executive lead, Rondine Molinaro we have someone who is passionate and knows what is required, but is looking to learn from the latest research and thinking,' he says. 'And our clinical team of full-time NMPs and substance misuse nurses working alongside both a GP and a consultant psychiatrist allows us to accept people with significant difficulties.'

The unit at Birchwood comprises 20 single occupancy bedrooms, including three on the lower floor for those with specific requirements or mobility issues. The service is for both men and women, including pregnant women and those with complex needs. The newly refurbished rooms and the superb on-site catering help to create that 'home away from home' feel that provides the right therapeutic atmosphere for clients' treatment.

'Within Birchwood we offer a flexible, individually tailored treatment regime, by carefully screening all potential admissions to ensure that we can safely assist the withdrawal of substances,' explains Birchwood's clinical director, Dr Mohan De Silva. 'Medical screening is done by a doctor. We look at GP medical history, previous hospital letters, any previous detox experiences, current medication and recent blood investigations. Having as complete a history as possible enables us to build a picture of the health of the patient and ensure their safety while at Birchwood.'

A range of programmes are offered for opiates, NSPs, stimulants, prescription medications and alcohol. These include a rapid five to seven day detox programme for individuals requiring urgent detoxification, a three to four day stabilisation and detoxification initiation that will be continued in a community setting, and both standard and complex detoxification programmes that can last between seven and 21 days, depending on the needs of the client. In addition, alternative regimes for alcohol detoxification can be offered, which are non-benzodiazepine based.



'Running Birchwood provides a chance to develop a bespoke inpatient treatment facility that can support a range of services... To achieve this, it was important to have the right team in place.'

'Having an experienced clinical team on site allows Birchwood to offer this range of interventions,' says consultant psychiatrist, Dr Julia Lewis from Pulse Addictions. 'As well as working with them to develop their clinical policies and procedures, I provide regular clinical supervision to their permanent team of experienced nursing staff who are committed to continuous service improvement. The aim of everyone involved in Birchwood is to ensure that the treatment on offer is safe, effective and meets the needs of the client.'

The client-centred approach goes beyond detox, and a range of mutual aid packages are offered, including 12-step, SMART Recovery, and access to the Life Ring service. In addition a weekly health clinic is available to identify wider healthcare issues and other chronic conditions that may have been masked by a client's drug taking.

The client-centred approach is something that Rondine Molinaro hopes to take beyond treatment provision to the running of Birchwood itself, with a long-term aim to transform it into a social enterprise. This would create the opportunity to provide a free detox space each month to someone who is unable to access funding through conventional means – 'someone who may need another chance,' she says.

Central to Kaleidoscope's culture is an understanding that detox is not a miracle cure, and for many clients may be just part of their journey – an ethos underlined by equipping clients with relapse prevention training, RPM medication, and take-home naloxone on leaving the facility.

What is very clearly on offer at Birchwood is the opportunity for people to reset their lives and make fundamental changes. 'While this is not a one-fix-wonder, hopefully it can inspire people to live life better,' says Blakebrough.

Birchwood House residential treatment centre welcomes referrals from a range of clients including statutory, criminal justice and private clients. To find out more please contact executive lead, Rondine Molinaro on 07773 211461 or email enquiries@birchwoodtreatment.com

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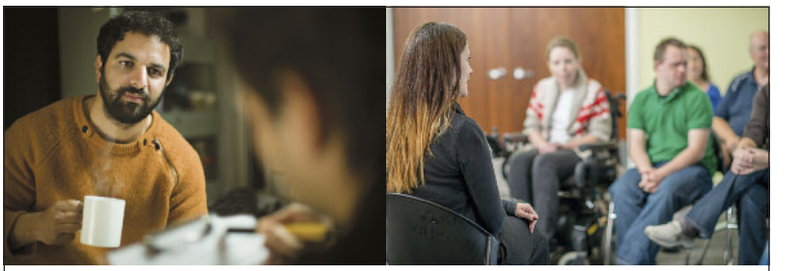

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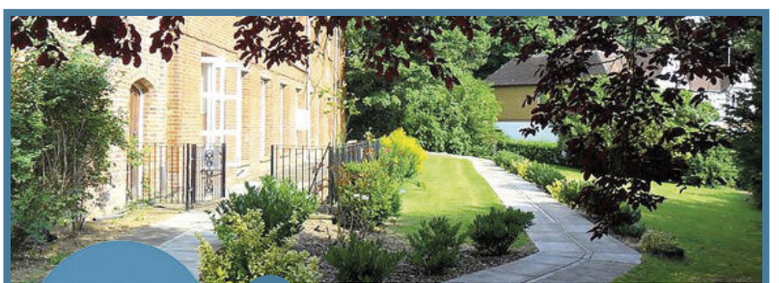

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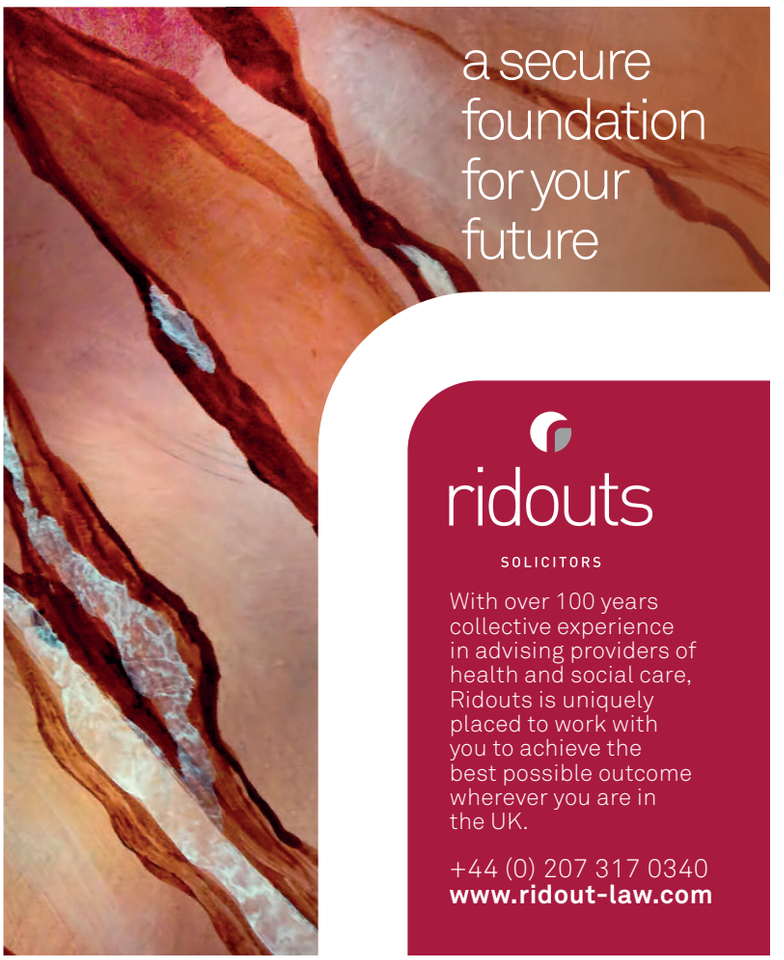

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