DRINK AND DRUGS NEWS ISSN 1755-6236 JULY/AUGUST 2017

DDN

SPECIALISED SUPPORT

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Inside: galvanising action for people with complex needs

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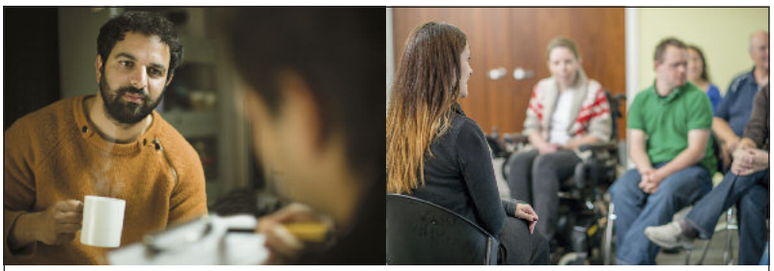

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EDITOR'S LETTER

'We've needed to hear these problems are not an add-on'

Problematic substance use rarely travels alone. The body of evidence keeps growing on the many strands that converge to make us lose direction, and we're familiar with how drug and alcohol use can crash through Maslow's hierarchy of needs.

We also talk a lot about revolving doors – to prison, debt, homelessness and a state of disconnection. So it's heartening to hear that senior representatives from many health and social care sectors will be coming together to discuss joint action on complex needs (page 8). This follows a call for evidence from the Office for Civil Society – and a detailed questionnaire that keeps substance misuse problems at the heart of a shared agenda. How long have we needed to hear that drug and alcohol problems are not the 'add-on' but symbiotic with mental health problems and all number of signs of personal breakdown?

As a clear case study we focus on veterans this month, through talking to the charity Combat Stress (page 6). It's hard to imagine the level of PTSD that drives many of those leaving the armed forces to self-medicate, but encouraging to hear that with the right dedicated support they can do 'very, very well'.

And as the summer rolls on, so does the schedule of festivals that bring many young people face to face with the irresistible opportunity to experiment. Kevin Flemen's article (page 14) should help to provide accurate advice, grounded in harm reduction.

We're doing a combined July/August issue for the holiday period, but will be online, on Facebook and tweeting through the summer. We're looking forward to hearing from you!

Claire Brown, editor

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

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GLASGOW CONSUMPTION ROOM MOVES A STEP CLOSER

A REPORT PRESENTED TO THE GLASGOW CITY INTEGRATION JOINT BOARD has identified a site for what could be the UK's first drug consumption room. The board officially approved the development of a business case for the facility late last year (*DDN*, November 2016, page 4) and an engagement process will now be carried out with the local community.

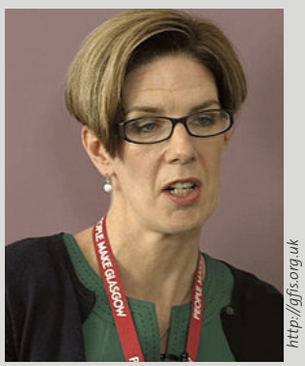
The proposed city-centre facility near the River Clyde would also offer heroin-assisted treatment alongside health and social care advice, peer support and treatment referrals. Last year's draft business case argued that the combined consumption room and heroin-assisted treatment could help reduce drug-related deaths and blood-borne virus transmission, as well as public injecting and drug-related offending. It could also improve service engagement for people with complex needs and reduce the burden on other health services.

The new report estimates the combined cost of the consumption room and heroin-assisted treatment at just over £2.3m per year, to be part-funded by redirecting existing resources of just under £900,000. The remaining £1.4m would be met by 'contingency funding for a period of no more than three years', says NHS Greater Glasgow and Clyde.

The lifetime cost to the health service of Glasgow's newly diagnosed HIV cases among drug users since 2015 is estimated at almost £30m, while a 2009 Scottish Government research paper estimated the 'total economic and social costs attributable to illegal drug users' in Scotland at around £3.5bn. Heroin-assisted treatment could potentially save almost £950,000 per year for every 30 people who access it, says the health board, with the treatment available only to adult heroin-dependent patients 'with previous unsuccessful treatment episodes'.

'The need for a safer consumption facility is about improving the health of those involved in public injecting,' said chief officer for strategy, planning and commissioning at Glasgow City Community Health Partnership, Susanne Millar. 'Our aim is to provide a route to recovery for a group of people often disengaged from support services.'

Public injecting placed a 'considerable' financial burden on the health, social care and criminal justice systems, she added. 'Existing research suggests the average spend on health, addictions, housing and criminal justice service for people in Glasgow with complex needs ranges from £1,120 and £3,069 per individual per month. These proposals are backed by evidence indicating safer drug consumption facilities not only improve health outcomes for people who inject drugs, but are also highly cost effective and contribute to savings for health and social care services.'



http://gfis.org.uk

'A safer consumption facility is about improving health.'

SUSANNE MILLAR

Meanwhile, the Scottish Drugs Forum has launched the final report of its expert working group on older people with drug problems. Not only are this population not engaged with treatment and at high risk of fatal overdose, they will 'increasingly become the norm' in services, says *Older people with drug problems in Scotland: addressing the needs of an aging population.*

SDF document at www.sdf.org.uk

SMOKING STATS

THE PROPORTION OF ADULTS IN ENGLAND WHO SMOKE HAS FALLEN to just over 15 per cent, according to a report from NHS Digital, ONS and PHE, down from just below 20 per cent at the start of the decade. The largest fall – from 26 per cent to 19 per cent – was among 18-24 year olds. The number of hospital admissions attributable to smoking has increased, however, from 458,000 in 2005-06 to 474,000 in 2015-16, and 16 per cent of all deaths in England in 2015 were estimated to be attributable to smoking. ASH said that while the drop in smoking rates was 'great news', smoking remained the leading cause of preventable death. 'One in two lifetime smokers will die from smoking-related disease, so a fall in smoking rates of this scale will save many thousands of lives in years to come,' said chief executive Deborah Arnott. *Statistics on smoking, England 2017 at www.gov.uk*

A&E OVERSIGHT

NINE OUT OF TEN A&E DEPARTMENTS ARE FAILING to identify young people with alcohol problems, according to research by the University of Surrey. A survey of nearly 150 departments found that young people were not routinely asked about their alcohol consumption or screened to identify those needing help. 'Ending up in A&E is often a wake-up call for people and forces them to assess their alcohol consumption,' said lead author Dr Robert Patton. 'However this is not always the case and sometimes involvement from a health care professional is what is required to support people in reducing their alcohol consumption.'

CHANGING TIMES

ABOUT A QUARTER OF A BILLION PEOPLE USED DRUGS IN 2015, according to UNODC's *World drug report 2017*, with around 29.5m engaged in problematic use. More than 6m people who inject drugs are living with hepatitis C and 1.8m with HIV, while trafficking routes and the range of substances available are shifting and diversifying at 'alarming speed', said UNODC executive director Yury Fedotov.

Report at www.unodc.org

NEEDS MUST

NEW JARGON-FREE GUIDANCE on meeting the needs of families affected by drugs and alcohol has been published by Adfam. Aimed at commissioners and service managers, *Making it happen* builds on the organisation's *Why invest?* resource from 2015. 'In consultation with family members, practitioners and commissioners around the country we have identified the key components and characteristics of good support for families and carers affected by substance use,' says the charity.

Document at www.adfam.org.uk

PSYCHOACTIVE RESEARCH

A NEW CENTRE FOR EXCELLENCE in NPS research has been set up at the University of Dundee, in partnership with the Scottish Government, Police Scotland and other bodies. The centre aims to 'support meaningful, targeted research to increase our understanding of such substances, help to reduce harm and support frontline services', said Dr Craig McKenzie of the university's school of science and engineering.

BRAVE FAMILIES

PHOENIX FUTURES has collaborated with the BBC and award-winning Lambent Productions on a two-part documentary showing life inside the country's only rehab for parents and children. *Addicted Parents: Last Chance to Keep My Children* was filmed in Sheffield's National Specialist Family Service and will be shown on BBC 2 at 9pm on 18 and 25 July.

'We are immensely proud of the very brave families that have allowed their stories to be told,' said Phoenix Future's chief executive, Karen Biggs. 'Their honesty and openness is challenging and emotional. We hope viewers will watch without prejudice or judgement. Most of all we hope the films give hope, comfort and encouragement to people affected by addiction.'

PUBLIC HEALTH BODY BACKS FESTIVAL DRUG TESTING

THE ROYAL SOCIETY FOR PUBLIC HEALTH (RSPH) has called for music festivals to provide drug safety testing facilities 'as standard', with the harm reduction measure also extended to city nightlife areas.

The call follows concerns about increasing purity levels of club drugs, with tests 'repeatedly' reporting ecstasy pills containing 150g and more of MDMA, compared to averages of around 50-80mg in the 1980s and '90s (DDN, March, page 4).

Drug safety testing pilots have already been carried out at UK festivals with the support of local police, and harm reduction organisation The Loop plans to extend testing to eight of this summer's events. RSPH research found that around a third of festival-goers and clubbers would 'definitely or probably' not take their drugs if testing revealed the strength or composition to be different than expected, while almost half said they would take less or 'be more careful'. Last year RSPH published a report that advocated decriminalising the personal possession of all illegal drugs (DDN, July/August 2016, page 4).

'While the use of stimulant club drugs such as ecstasy can never be safe, and RSPH supports ongoing efforts to prevent them entering entertainment venues, we accept that a certain level of use remains inevitable in such settings,' said RSPH chief executive Shirley Cramer. 'We therefore believe that a pragmatic harm reduction response is necessary.'

Testing facilities provided an opportunity to 'impart practical harm reduction advice to an audience who would not normally engage with drug services', she continued. 'We urge events companies to make these facilities a standard part of the UK festival and clubbing landscape, and we urge both local and national police and public health authorities to provide the support that will enable this.'

'We accept that a certain level of use remains inevitable in such settings.'

SHIRLEY CRAMER

'We believe that prioritising public health over criminal justice for drug users at a time of growing concern about drug-related deaths at festivals and nightclubs can help to reduce drug-related harm both on and off site,' added The Loop's director, and professor of criminology at Durham University, Fiona Measham.

Read Kevin Flemen's article on ecstasy on page 14.

FLAWED FINDINGS?

EXPENSIVE DIRECT-ACTING ANTIVIRALS (DAAs) for people with hepatitis C 'do not seem to have any effects on the risk of hepatitis C-related morbidity or all-cause mortality', according to a review for the Cochrane Library. While DAAs – which cost around £30,000 per patient – seem to eradicate the virus from the blood it is questionable if this leads to 'no hepatitis C in the body and improved survival and fewer complications', says the review. However 'several limitations' meant the quality of evidence was 'very low', the authors acknowledge, while a letter to the Guardian from leading hepatology professors and Hepatitis C Trust CEO Charles Gore stated that as the review analysed short-term clinical trials that 'were neither designed nor powered to assess mortality' it was 'fundamentally flawed'. *Review at www.cochrane.org*

Review is fundamentally flawed.

CHARLES GORE

OVERDOSES UP

THE TOTAL NUMBER OF DRUG OVERDOSE DEATHS in Europe has risen for the third consecutive year, according to EMCDDA's European drug report 2017. There were 8,441 fatal overdoes, 'mainly related to heroin and other opioids', in the 30 countries covered by the report in 2015, compared to 7,950 the previous year. While previous European drug reports have highlighted the exponential increases in NPS being detected for the first time, 2016 saw the number fall to 66 from the previous year's 95. Although this signifies a 'slowing of the pace', it still represents more than one per week and NPS remain 'a considerable public health challenge', the document stresses. *Report at www.emcdda.europa.eu*

DEADLY DRINKING

AN AVERAGE OF 22 PEOPLE PER WEEK DIED of an alcohol-related cause in Scotland in 2015, according to an NHS Health Scotland report, a figure that's 54 per cent higher than in England and Wales. The following year saw 10.5 litres of pure alcohol sold per adult in Scotland, enough to exceed the chief medical officer's recommended 14 units by 44 per cent every week of the year, says Monitoring and evaluating Scotland's alcohol strategy. 'It is worrying that as a nation we buy enough alcohol for every person in Scotland to exceed the weekly drinking guideline substantially,' said lead author Lucie Giles. 'The harm that alcohol causes to our health is not distributed equally; the harmful effects are felt most by those living in the most disadvantaged areas in Scotland.' *Report at www.healthscotland.scot*

GET TRAINED

FREE ALCOHOL INFORMATION and brief advice (IBA) training in Islington is being offered by Blenheim in association with Islington council. 'Islington experiences some of the highest levels of alcohol-related harm in London,' said council public health strategist Angelina Taylor. 'We are delighted to be working with Blenheim to deliver training to frontline staff across Islington in order to support our residents.' *More information at blenheimcdp.org.uk/training/iba*

FAST SUBSTITUTION

THE SCOTTISH MEDICINES CONSORTIUM has recommended the fast-dissolving buprenorphine oral lyophilisate Espranor for restricted use within NHS Scotland. Current licenced buprenorphine tablets can take up to ten minutes to dissolve, which often involves close supervision. 'Having another choice of treatment available is always a cause for celebration, and by now being able to offer a simpler form of buprenorphine we may increase its use and reduce some of the problems seen with conventional pills,' said CEO of Faces and Voices of Recovery, Annemarie Ward.

Having choice of treatment is always a cause for celebration

ANNEMARIE WARD

For many ex-service personnel the transition to civilian life can be a struggle, and it's all too tempting to turn to the bottle to cope. **DDN** hears how specialist support provided by the charity Combat Stress is helping veterans get back on their feet

Battle lines

Adjusting to civilian life after a career in the armed forces can be hugely challenging, and that's even without the PTSD that many veterans may be struggling with. Around 15,000 people leave the forces every year, and many try to cope with the transition by self-medicating – especially with alcohol, something that may have been a central part of their forces life.

It's little surprise therefore that last month an Addaction report by researchers at Sheffield Hallam University, and funded by the Forces in Mind Trust, found that ex-military personnel with substance problems are far more likely to succeed in their recovery if they access veteran-specific services.

'Following service in the armed forces, a small but measurable number of people struggle to transition into civilian life and can turn to addiction when trying to cope with these pressures,' said Forces in Mind Trust chief executive, air vice-marshal Ray Lock. 'It can be very difficult for such vulnerable people to have the confidence to speak up and ask for help. In some cases they may not even be aware that such help is available.' This is backed up by research from Surrey-based charity Combat Stress, which found that veterans may put off seeking help for years, even decades, with many not accessing services until they're in their 60s (*DDN*, June, page 4).

Combat Stress is the UK's leading mental health charity for veterans, helping those struggling with PTSD, depression, anxiety and other issues. Originally founded just after World War I, it currently has more than 6,000 people registered for support and also offers specialist substance misuse services, which are always free of charge for veterans. The organisation works closely with the NHS to identify former service personnel who may have substance issues and help them engage with treatment.

Donna Bowman is a specialist veterans substance misuse nurse for Combat Stress, based at the Queen Alexandra (QA) Hospital in Portsmouth. 'I'd been a specialist nurse for the hospital's alcohol team for about seven years when I found out about this role, and the more I heard, the more I thought it sounded really interesting,' she tells DDN. 'My caseload is always between about 30 and 40, and I've seen around 130 veterans in total now.'

While most clients come from the hospital she also gets referrals from drug and alcohol services, GPs and veterans' outreach services, along with some self-referrals. 'What really appealed to me about the role was that you could do really assertive outreach in the community – you could pick up the veterans in the hospital then follow them up,' she says. 'I found that really exciting and rewarding as the one thing I always thought was a shame with my alcohol patients was that we couldn't follow them up in the community.'

Another positive is that the veterans are 'a great group of people to work with', she says. 'Once they get on a mission about stopping drinking, and they have support, they do very, very well.'

While that sense of commitment and determination can stand them in good stead when it comes to recovery, in other ways a military background can act as a significant barrier, however. 'They're just so proud,' she says. 'Plus in the military they're used to being told to just get on with it, not ask for help and not really talk about things. So when they're out in civilian life they think they should be able to cope with things themselves. They can be really hard to reach, and they leave it so long that by that time their lives can be in a state of ruin.'

A key skill when dealing with veteran clients is simply being approachable, she stresses, as is the ability to slowly build up trust. 'That can take a while, but often they can be very sick when they come in as they've left it so long.'

Another crucial aspect is simply that 'you do what you say you're going to do', she stresses. 'It can take a while to establish their trust, but once you've got it you've got it forever. I've worked in intensive care so I've got also quite a lot of assessment skills, and unless someone can get their health back on track their life is

More on mental health at www.drinkanddrugsnews.com

going to be pretty miserable. So I'll go to people's houses, and I'll get GPs and ambulances out because I'm not happy with how they're looking.'

For the vast majority of her clients the problem is alcohol rather than drugs, she says. 'It was such a massive part of their culture when they were in the military that it tends to be their crutch when something goes wrong. We do see people with drug issues, but it's quite rare.'

She also provides support for family members on house visits, along with referring them to services like Al-Anon. Signposting her veteran clients – to housing, education, training, health and other services – is also a 'massive part' of the role, particularly as it's not uncommon for some veterans to end up homeless. 'I work with a charity called Veterans Outreach Support, which has a drop-in service based in a maritime hotel – there's about 20-plus services under one roof, so veterans can turn up on the day and be seen by mental health teams, the Royal British Legion, [armed forces charity] SSAFA and loads of different services. So I have access to all of those at my fingertips really.'

Given the trauma that many veterans will have been through and the difficulties in adjusting to civilian life, could the armed forces themselves be doing more to provide support? 'I do think they could,' she says. 'I think it might be getting better, but I do think in the transition period from when they leave the forces they could perhaps explain a bit more about where to seek help for alcohol problems and things like that, and provide information about what's in their area in terms of support. When they come out it's so different from being looked after and having that structure.'

Someone who can attest to that is her client Michael, whose Royal Navy career lasted more than 21 years. After leaving he worked full-time as an engineer on army camps, but it was when the work stopped that his drinking got out of control. 'It just got progressively worse and worse, until it snowballed into about a litre of vodka a day,' he tells *DDN*. 'A ridiculous amount.'

Despite the extent of his drinking he found it hard to even acknowledge that he had a problem until his first contact with Combat Stress. 'What made me sit up and take notice was the first time I ever met Donna,' he says. 'That was in January 2016, when I was in the QA hospital for the second time with a broken shoulder. She just turned up at my bed one day and the light bulb went on over my head. Up until then it hadn't really dawned on me because I couldn't see the wood for the trees. I was too close to the problem.'

Although he's making good progress he's aware that it can be a long road. 'I've had a couple of blips,' he says. 'I went without a drink for about 16 months and I thought I had it under control, but I didn't. It's like any addiction, it comes up and kicks you in the backside, but generally I'm feeling quite optimistic.'

His only other experience of treatment, at a drug and alcohol drop-in centre, made him realise how much he values the veteran-specific service at Combat Stress. 'The atmosphere and surroundings were not what I'd call conducive to help,' he says. 'A lot of people were only there because they had to be as part of their ASBOs or whatever, and were talking about how they were going to be taking drugs the moment they left.' In common with other people with a military background he also struggled with the 'sharing' aspect of some treatment. 'I've always preferred the one-on-one – I'm not a great group person – and I get on with Donna and all her colleagues brilliantly.

'The thing I like is that they talk *to* you,' he says. 'They don't talk at you or down to you – they talk it through, which being ex-service is what you need. I honestly don't think I'd be here if it wasn't for Donna and her colleagues. I can't praise them enough. It made me realise that somebody actually cared.'

www.combatstress.org.uk

Addaction report – *It's not just about recovery: the Right Turn veteran-specific recovery service evaluation*, at www.fim-trust.org

TIME FOR ACTION

Social action is the way forward in tackling complex needs, hears **DDN**

The All Party Parliamentary Group (APPG) for Complex Needs and Dual Diagnosis recently launched a call for evidence around social action (DDN, May, page 5). With a detailed questionnaire, the group wanted to know what factors could really make a difference in helping people with complex needs. How could challenges be addressed around giving access to housing, employment opportunities and mental health services, alongside substance misuse support?

'There are a lot of complex needs out there and not enough integrated services to address them,' says Lord Victor Adebowale, chief executive of Turning Point, which provides the secretariat for the group. 'What we're talking about is a big problem – 70 per cent of people in drug services and 86 per cent of people in alcohol services experience mental health problems.'

Add to that the 55 per cent with 'severe multiple disadvantage issues' and the four out of five prisoners with at least two mental health problems and it's easy to see how the cost to society is reckoned to be at least £10bn a year. Unsurprisingly, most suicides occur among patients with a history of complex needs, and many psychiatric patients have substance misuse problems.

The Office for Civil Society, with its newly appointed minister Tracey Crouch, approached the APPG to undertake a call for evidence around the notion of social action – the idea that community-led initiatives and involving people with lived experience should be a natural and logical part of service design.

'What I mean about social action is people coming together to improve their lives and solve the problems they report in their community,' says Adebowale, adding that it's an area that Turning Point knows well through its work on 'connected care frameworks'.

The call for evidence involves a detailed questionnaire, circulated around many organisations including the substance misuse sector. The response has been heartening, says Adebowale, with detailed contributions from 'a massive range of organisations... there's clearly a lot if interest out there'.

'We've received a lot of evidence from peer mentors

> 'What we're talking about is a big problem – 70 per cent of people in drug services and 86 per cent of people in alcohol services experience mental health problems.'
>
> LORD VICTOR ADEBOWALE

More on complex needs at www.drinkanddrugsnews.com

themselves about how social action contributes to people's recovery, self-worth and confidence, talking about their routine and the benefits peer mentoring can have – lots of living proof that change is possible and offering hope,' he says. 'So the question is, how can social action improve outcomes, prevent crisis, support recovery and develop more responsive services for people with complex needs?'

Next stage will be to produce a report over the summer, bringing together case studies, examples, key learning themes and ways forward, based on the evidence received and the discussions that take place at an imminent roundtable event for health and social care leaders.

'We've got lots of positive evidence that social action improves employment skills, and we've also heard a lot on reducing stigma, both in the community and in the individual,' says Adebowale. Many of the suggestions involve 'breaking down the barriers between people with lived experience and so-called professionals' and improving understanding of how to reduce stigma as a means of promoting recovery.

'We've also had lots of evidence about peer mentoring giving a sense of belonging and responsibility,' he adds. Build on Belief (BoB) were among those to talk about social actions and peer-led activity as a counter to loneliness and isolation, 'which I think is a real issue here for people with complex needs.'

So how will this work galvanise the political process and have an impact? 'That's one of the challenges for the roundtable and the whole point of this work,' says Adebowale. 'We're building the evidence case and there are challenges. Social action programmes are often dependent on a few, or just one creative person, and that person can disappear. Services take time to set up and become effective, and one problem at the moment is that funding cycles are often very short for projects to develop. And there can be issues – boundary issues and that kind of stuff – around getting individuals to work in an effective environment.'

But he is optimistic on 'moving the needle on engagement activity': 'We've received quite a lot of evidence about what the keys to success are – dedicated staff, a partnership approach and personalised support for individuals. We've got some key people involved, including the minister for civil society... it's also exciting that we've managed to engage NHS England.'

Key players are expected at the roundtable, including chief executives and directors of the NHS, charities, funding bodies, LGA, and Collective Voice.

'We're looking to make this work and to lift the lid on it – and to really shift what government does to encourage commissioners to learn from this,' he says. 'It has to be quality led and outcome based – and it has to be delivered in a way that makes sense, rather than cutting corners.' **DDN**

WHAT WOULD MAKE A DIFFERENCE TO ME?

Given I have a number of complex issues and engage with multiple agencies, I was asked by DDN to write a little about my current experience.

I'm a 48-year-old single white British male and not only do I have HIV, but also ongoing mobility issues due to post-thrombotic damage in both my legs. I have multiple mental health issues: as well receiving help for a history of addiction I also suffer from a persecution complex, anxiety, depression and paranoia, all of which have worsened as I try to navigate through welfare reform.

Having been in receipt of Personal Independence Payment (PIP) for the last four years, I was invited on 2 June, albeit a year early, for reassessment of my mental and physical health needs. However, despite both my physical and mental health worsening, my score went from 13 to zero in the space of 18 months.

Despite numerous times offering to provide further medical and photographic evidence at my assessment, I was repeatedly told, 'If you don't stop offering me medical evidence then we won't have time to complete your form.' I subsequently failed my assessment and am currently appealing their decision, which unfortunately started the ball rolling for the problems that were to come.

Despite being in receipt of a number of benefits, because my PIP was suspended housing benefit also decided to stop any payments, despite me being in receipt of ESA [Employment Support Allowance], which subsequently meant letters from my housing association threatening eviction because my rent wasn't being paid. I was never informed of any decisions until after they were made and had started affect my circumstances.

After speaking with DWP they informed me that this was purely an error on behalf of housing benefit and in fact they have the facility to check what claims are current for each client. However if they don't know how to use the system, or fail to use it, the knock-on effect can be devastating.

Because I appealed against their decision, in the last six weeks not only has my benefit entitlement been cut by around 70 per cent, but also because of employee incompetence my housing benefit was stopped and in the last week I've received three letters of notice to quit by my landlord, despite numerous calls to DWP and housing benefit to rectify this situation and their error.

Not only has it affected my physical health, but also because of what I had gone through in the last month I couldn't foresee doing the same for the next 18 months while I go through the appeal and tribunal process. I wanted to end my life.

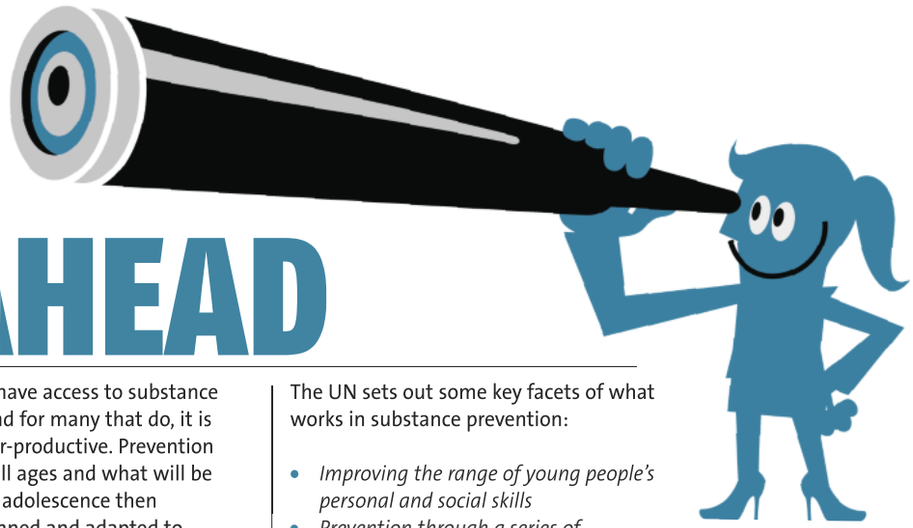
It has left me unwilling to deal with these agencies but I intend to follow my case through to tribunal for an independent body to review my application and circumstances. I still face a long and hard fight to receive my correct entitlement, while also having to battle through non-curable physical health and worsening mental health.

As I look around my city and peer group it's not something I can see improving any time soon, because despite having the systems and ability to share information, employees are using them in a completely different way to other services. If staff aren't trained properly or do any cross agency work, then unless they use the same system in the same way, it's doomed to fail.

It's not something that should be happening after all the work that's been done and the money that's been spent over the last decade to set up these systems. There was no reason for me to be under the threat of eviction.

Joining up access to housing and employment opportunities and specialist services for mental health and substance misuse, and then actually using the same systems in the same way, would make a massive difference when helping people like me to address their multiple complex needs.

Our correspondent's name has been withheld to safeguard sensitive information



LOOKING AHEAD

Prevention work with young people is an investment in the future, says **Michael O'Toole**

Many young people do not have access to substance prevention education – and for many that do, it is ineffective or even counter-productive. Prevention needs to be different for all ages and what will be effective evolves as children grow into adolescence then adulthood. It needs to be carefully planned and adapted to maximise its relevance and usefulness.

It is crucial that evidence-based approaches are followed in a variety of settings for young people, as well as the adults in their lives. Not only must prevention be age-appropriate, but there are also different approaches required depending upon risk:

Universal *These are broad school and community programmes for all young people to better understand how to resist riskier behaviours.*

Selective *Some programmes identify issues for sub-groups who are clearly vulnerable to a specific risk and help them to overcome problems particular to them.*

Indicated *Young people can find ways to reduce specific harms by considering objective and relevant information resources.*

One of the common ineffective approaches is to simply provide young people with information about substance harms and their legal status and then expect that safer choices will naturally follow.

Another approach seen to be ineffective is trying to scare young people off drugs through fear arousal or shock tactics. Evidence shows that a holistic approach to the development of values, skills and knowledge, which empowers young people to protect themselves in a range of risky situations, is much more effective.

The UN sets out some key facets of what works in substance prevention:

- *Improving the range of young people's personal and social skills*
- *Prevention through a series of structured, interactive sessions over multiple years*
- *Delivery by trained teachers or facilitators*

Young people need to be thinking, engaging, discussing and building their own resilience to the risks that alcohol and drugs may present. We know that presenting information alone, especially when intending to evoke a reaction, will not help change behaviour for the better.

No single approach can prevent a young person experimenting with alcohol or drugs. What we need is to build upon their capabilities and potential, rather than telling them not to misuse substances or trying to scare them. What does work is empowering young people to build upon their skills, knowledge, positive attitudes and ambition to be more resilient. It is therefore critical that we understand their perspective to improve the effectiveness and impact of our work and programmes.

Prevention services are a crucial investment in the future. Public Health England estimates that drug and alcohol harm costs the UK £36.4bn every year, but there is no aggregate sum for the loss of ambition and harm to young people's futures.

Michael O'Toole is chief executive of Mentor UK. He will be speaking at The National Substance Misuse Conference on 13 September, register at rsbevents.com

MEDIA SAVVY

The news, and the skews, in the national media

ALCOHOLISM IS A STRANGE CONDITION. If you survive the drinking stage, and many don't, it has relatively little to do with alcohol, which is merely the drug with which the alcoholic treats herself. It is, rather, a way of thinking, and continues long after you have stopped drinking. It is a voice in the head: a malevolent voice that wants you to die. I certainly see it that way: it makes it easier to pick my way through the days if I know what, exactly, I am dealing with. Is this the voice speaking, or not? Which one made a decision, and which one doubted it? To discover the true root of any plan can require forensic vigour, and much time. It is perpetual inner warfare.
Tanya Gold, *Guardian*, 24 June

BY OPPOSING MINIMUM UNIT PRICING, the Scotch Whisky Association – whose members include global alcohol producers like Diageo, Pernod Ricard and Beam Suntory – aren't standing up for Scotch whisky, they are supporting drinks at the very cheapest end of the market which are causing untold damage to people's health, their families and our communities... It is absolutely unforgiveable for these companies to continue to put their profits before people's lives.
Alison Douglas, *Scotsman*, 16 June

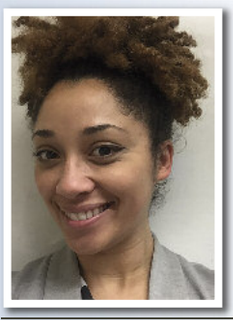
ALL DRINKERS TODAY are aware of the risks of excessive alcohol consumption. It's why the majority of people don't actually drink to excess. Genuine alcoholics, meanwhile, are hardly going to be deterred by labels telling them something they are already painfully aware of... The crusade to slap morbid images on drinks bottles is part of wider strategy of 'gesture policymaking'. Those proposing the move know it will have no meaningful impact, but they have to be seen to be doing something. It is patronising to consumers, and a waste of time and resources for manufacturers.
Benedict Spence, *Spectator*, 13 June

THE DRUG WAR CONTINUES to be a massive failure, and even though the dark web has made drug buying safer – and even drug use safer – it is still inferior to a regulated market with clear product data.
Mike Riggs, *Newsweek*, 1 July

DRUG USERS have long been one of the most demonised and marginalised groups in society – and a low priority for policymakers. This simply can't continue. A public health crisis and loss of life on the scale currently being witnessed warrants an immediate, and unapologetically progressive response.
Mary O'Hara, *Guardian*, 27 June

CLINICAL EYE

A need to inspire



We neglect our student nurses at our peril, says *Ishbel Straker*

I HAVE A DREAM.... that one day all student nurses will be made to feel welcome while on their placements... that student nurses will be nurtured and valued through their journey on hospital wards and community settings. They will arrive with a mentor already named and a timetable set, which will maximise their learning outcomes. They will be encouraged to ask questions and feel comfortable to highlight areas for improvement within services.

While undertaking my nurse training my learning experiences varied. On some placements I was met with the 'dream', and on others I was met with a response of 'we didn't even know you were coming' – not the best start to a 12-week relationship!

What concerns me from a clinical director's point of view is that nationally we are having a nurse recruitment crisis. We are unable to fill posts with permanent staff, let alone retain them. Our international drives have been unsuccessful and now our university intakes are looking worrying.

The bottom line is that we have a duty of care to encourage and nurture our students. We need to position them for the best educational experience they can have in order for the next generation of nurses to come out as well-rounded clinicians.

This leads me onto the student's vocational experience: how are we to attract nurses into the field of addiction when this is not a standardised placement area? With the increase of awareness around comorbidities in addiction, why are we not seeing more general nursing students coming through our services?

You might say this is because of the lack of placement opportunities, and I can say that in my current and previous role I made it the top of my agenda to have our services filled with student nurses, to which some universities stated they would not use non-NHS placements. This is an interesting concept when the NHS has a consistently reducing portfolio of addiction services.

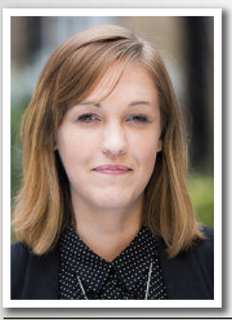
What is my point? Well, I want students to be welcomed and nurtured when on placement in our addiction services, so much so that they notice, just as I did as a student, that this field is different to any other in nursing. I want students to ask at the end of their placements with us to contact them should any jobs arise in the future, because that placement stands out more than any other in the whole of their three years' training as one which they want to come back to as a qualified member of staff.

What better accolade than when a student nurse returns home to make their career?

Ishbel Straker is clinical director for a substance misuse organisation, a registered mental health nurse, independent nurse prescriber (INP), and a board member of IntANSA.

LEGAL LINE

FIGHTING BACK



You have clear evidence to challenge CQC – so prove it, says *Nicole Ridgwell*

IN DDN'S ARTICLE 'MARKET FORCES' (June, page 14), Dr David Bremner of Turning Point was quoted as stating that providers needed to 'push back against CQC... I'm a big fan of low threshold prescribing – but try and get that past CQC now'. So how should you prepare for a CQC visit where you can foresee criticism of certain aspects of your service?

There is a concern that CQC may fundamentally misunderstand the substance misuse services they are now regulating. This conviction that CQC makes arbitrary decisions, which cannot be reasoned with, has led to some providers choosing not to challenge criticisms. Yet, as Dr Bremner identifies, providers choose which treatments they offer based on their analysis of what works best.

Unfortunately, regulators can sometimes take what appears to be an almost political stance in relation to the service being regulated. CQC's recent interactions with the residential learning disability sector, for example, originate in the Winterbourne View Hospital Serious Case Review, which highlighted the horrors of institutionalisation. The Department of Health report concluded that patients stayed at Winterbourne View for too long and were too far from home. To the surprise of the sector, CQC took this generalised lesson and translated it into a number: six. Providers with more than six residents suddenly found themselves on the wrong side of a policy decision and facing criticisms when they had previously been considered examples of excellence within the sector.

Much of the sector is now fighting back. Providers are preparing for the criticism, compiling evidence, seeking legal advice, and preparing to challenge CQC inspection reports. In these cases they are succeeding – CQC has confirmed that they will not be adopting 'six as a rigid rule'.

It is not surprising that low-threshold prescribing would face similar opposition from CQC. To the layperson, the concept that a substance misuse programme would not have the finite goal of abstinence is confusing to say the least. To a regulator, it presents different challenges: if the goal is not abstinence, then what is it and how is it measured?

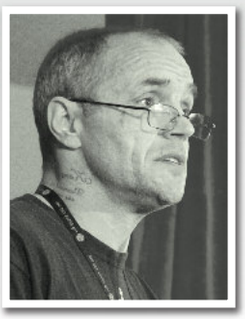
Providers must step in and assist themselves and CQC by demonstrating why their decision is appropriate to their client group. This may initially seem challenging, but it is merely a reiteration of the exercise you conducted when you first decided what treatment options you would offer and why. The difference is that you now have the advantage of knowing your client group and have the evidence at your fingertips.

Providers must repeat the exercise and gather the available data. Do you believe that low- threshold prescribing increases client contact and engagement, that it decreases drug-related deaths or the risk of HIV contraction, that clients who access your service demonstrate an increased ability and willingness to access other health services or come to your service of their own volition having previously had a poor record of engagement? If so, prove it and then show that proof to CQC.

Inspectors may attend your service with initial prejudices, but you have the power to change their minds and, in doing so, change their understanding of the sector.

Nicole Ridgwell is solicitor at Ridouts LLP, a practice of health and social care lawyers, www.ridout-law.com.

BEGINNING OF THE END



End of life care is a difficult topic to discuss. **Kevin Jaffray** suggests ways to start the conversation and provide better palliative options

End of life care has many different elements to it, including palliative care, hospice, care for the carers, and much more, but underlying all the many aspects of care should be dignity and respect.

For many it can seem like a taboo subject, and few patients report having any discussions around end of life care with their GPs, despite the relevance in relation to their condition. We all die – so how do you introduce the conversation? It's a discussion that needs to happen while there are options to put a comprehensive, person-centred care plan in place.

Such a complex area presents numerous dilemmas. Family values and ideals may differ as emotions run high, and there are all kinds of factors to take into account: cultural and socioeconomic influences, religious beliefs and core values, professional differences, political and financial restrictions – the list seems endless.

The National Council for Palliative Care (NCPC)'s guidance to doctors defines end-of-life care as helping people 'with advanced, progressive, incurable illness to live as well as possible until they die'. It helps both the patient and their family throughout the last phase of life and into bereavement and as well as including management of pain and other symptoms – and just as important, it provides psychological, social, spiritual and practical support.

NCPC also recognises that 'if end of life and palliative care were better and more widely understood, then this might enable better conversations between health and social care staff and people about death and dying, as well as services that meet their needs.'

Put simply, the principle aims of end of life care include:

- *Placing the person at the centre of the caring process.*
- *Consulting and involving the person in decisions regarding their care.*
- *Recognising that in addition to their physical symptoms, people have emotional, social and spiritual needs that should be addressed by a multi-disciplinary team.*
- *Maintaining and enhancing quality of life for individuals and their families wherever possible.*
- *Providing bereavement support for families and carers after someone has died.*

Making sure that these principles are met efficiently and professionally is a core value to all aspects of care and support. The process can be set in motion by collating a one-page profile that outlines what is most important to the individual receiving care: What are their expectations during the process, their fears, and their concerns? Who is closest to them and who might the individual perceive as being essentially involved in the care process? What are their significant needs, what kind of environment are they living in, and what are the key aspects of their quality of life?

If there is no supporting family and the socio-economic background is one that reflects a negative environment involving homelessness, a history of substance use, progressive underlying mental health condition, and no recognised community connections, should the approach to care be any different?

In all cases, treatment grounded in equality and diversity is essential, but addiction can have a double impact on end of life care – particularly when it involves taking medications to alleviate pain and other symptoms during treatment.

Social activist David Dellinger highlighted ways in which attitudes to substance use could have an impact on care. In some cases healthcare providers were heavily biased against 'addicts', while nurses had been reported to discount pain reports and under-treat pain in patients who had a record of substance use.

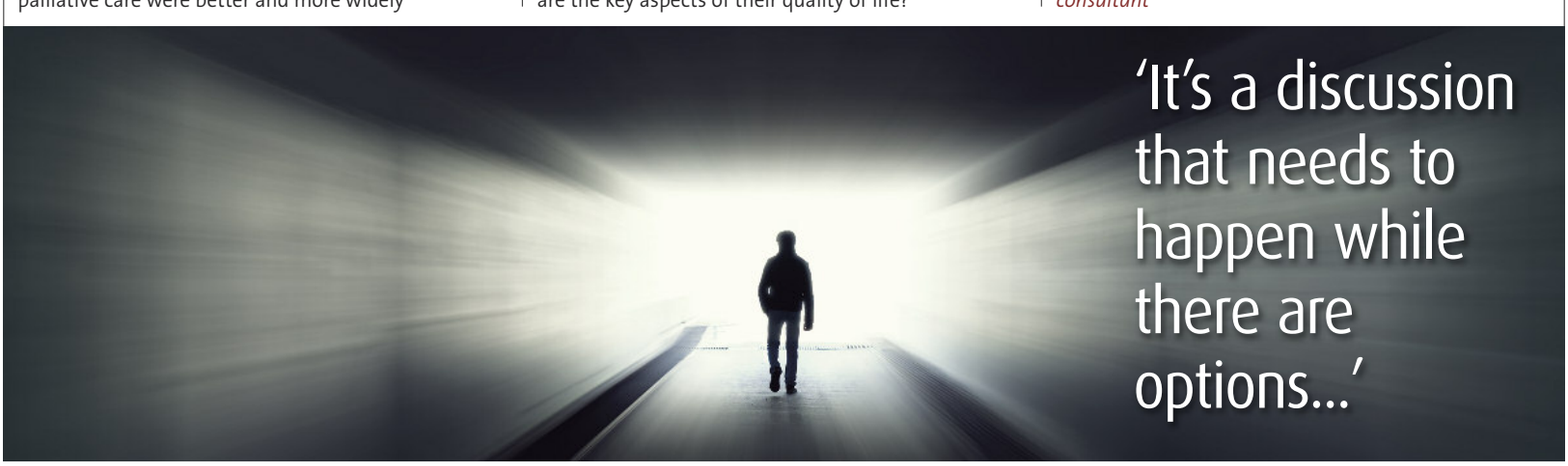
In many cases, those entering end of life care were not screened or treated for substance use or addiction issues, meaning that they did not receive the most appropriate treatment.

Various approaches can be adopted to improve the situation. First and foremost, clear and direct models of care, which identify potential risks and barriers, should be stored on a national database for easy access. This document could include personal testimonies from carers, family members and nurses involved in the end of life care process, showing which provision would be most effective.

This would also serve as a guide to care based on best practice, providing a space where innovative care approaches could be showcased. Relevant training should also be a necessity for all professionals in recognising signs of substance misuse, and in developing an understanding of the risks involved in inappropriate treatment.

Clear and direct strategies alongside effective support networks for family, friends and caregivers will not only improve practice and care, but enhance outcomes for all those involved in this difficult process.

Kevin Jaffray is an independent trainer and consultant



SURVEY

I'm worth...

To mark World Hepatitis Day, the *I'm Worth...* campaign is launching a survey – and needs **your** views

BECOMING FREE OF HEPATITIS C

In England, around 160,000 people are infected with hepatitis C, the majority of whom are from marginalised and under-served groups in society, such as people who inject drugs (PWID).[1]

If left untreated, hepatitis C can cause serious or potentially life threatening complications like liver cancer.[2]

To mark this year's World Hepatitis Day on 28 July, *DDN* is partnering with the *I'm Worth...* campaign to conduct a survey of *DDN* readers. *I'm Worth...* aims to address the stigma that many people with hepatitis C face, encouraging and empowering people living with hepatitis C to access diagnosis, care and services no matter how or when they were infected.

The *I'm Worth...* survey aims to gain insight into the opportunities and challenges that you are faced with when working with those affected by hepatitis C. We are hoping to understand the barriers to patient engagement, the most effective channels of communication, the resources available and any unmet needs.

We want to hear from YOU, the people working day to day with PWIDs and other marginalised groups where there is a high prevalence of people with, or at risk of, hepatitis C.

Please complete our short survey to share your thoughts on what support, resources and care could improve the lives of those affected by hepatitis C.

1 *Public Health England. Hepatitis C in England: 2017 Report. http://www.hcvaction.org.uk/sites/default/files/resources/hepatitis_c_in_england_2017_report.pdf [Accessed: July 2017]*

2 *NHS Choices: Hepatitis C. http://www.nhs.uk/conditions/hepatitis-c/pages/introduction.aspx [Accessed July 2017]*

The I'm Worth... campaign has been developed and paid for by Gilead Sciences Ltd, a science-based pharmaceutical company. Content development has been supported by input from numerous patient groups with an interest in hepatitis C in the UK.

HCV/UK/17-04/NM/1634b – July 2017

We want to hear from **YOU**, the people working day to day with PWIDs and other marginalised groups where there is a high prevalence of people with, or at risk of, hepatitis C.

Access the survey at
https://drinkanddrugsnews.com/im-worth-survey/

For more information on the campaign and to access materials designed to support people living with hepatitis C please visit **www.imworth.co.uk**

HEIGHT OF ECSTASY

Summer brings the festivals – and a new young crowd experimenting with MDMA. **Kevin Flemen** gives the guide to staying safe

'Who is Leah Betts?' The question, from a recently qualified social worker on an NPS course, brought home to me some important issues. Leah died in 1995, aged 18, after using MDMA and drinking a large quantity of water. Campaigns by her family, the media and advertising agencies saw her posthumously become the 'poster girl' for the dangers of MDMA.

That was 1995, and my newly-qualified social worker was a baby when this happened. She and a whole cohort of children and young adults have not grown up in the shadow of Leah's death. They didn't read about it in the papers, see the video at school or learn about it from earnest drug educators.

This matters now more than ever. This MDMA-naïve generation are going out at a time when MDMA pills have never been as strong, cheap, or widely available. Alongside the pills containing dangerous adulterants, powder and crystal MDMA may also be adulterated or misidentified.

Alongside the Leah question, I hear another: 'Frank – is that still going?' The days when the drugs helpline enjoyed TV adverts and a budget allowing for innovative cross-platform promotion are long gone. It became a casualty of cuts along with the club outreach that helped reduce the risks to a generation of young people.

So with exams coming to an end and the festival season underway, it is imperative that those MDMA harm reduction messages are dusted off, refreshed and communicated to the new generation of users.

As ever, drug terms and slang vary from place to place and over time. The drug MDMA is variously known as Mandy, Molly, ecstasy, E and XTC and some young people may not be aware of its 'proper' name. Terms may link to form ('ecstasy' had referred primarily to pills, MDMA to powder and crystals) but this isn't always the case.

Pill strength has increased significantly over the past couple of years and has become a key concern. There is no routine, consistent monitoring of available pill strengths in the UK, so comparisons are partly estimates. Back in the late '80s and early '90s, MDMA pills contained around 80mg per pill and would retail for £5-10.

Looking at the range of pills currently available on dark web sites such as Dream Market, there are a few at the 160mg mark but most claim strength of between 220mg and 250mg, so average pill strength has probably trebled.

New production methods and the massive marketplace that is the dark web have seen manufacturers competing on strength and price, so low cost is no longer indicative of a low-dosed pill. For older users accustomed to swallowing two or three pills at a time, or for younger users with no tolerance, these high dose pills can cause fatal overdoses.

CRYSTAL CONTAMINATION

Just as pills can vary significantly in terms of dose and composition, the same is true for products sold as powder or crystal MDMA. Alternative substances or adulterants may be present and whereas one can check online for pill warnings, powders and crystals are harder to identify visually.

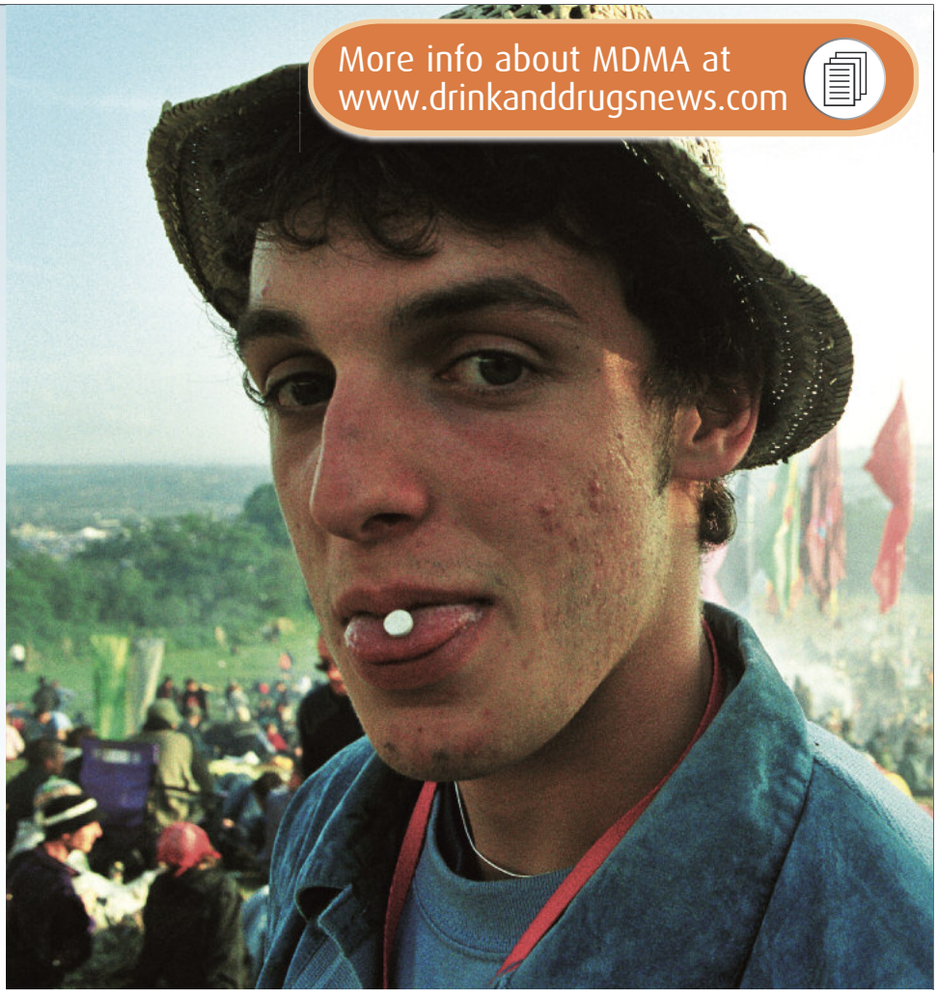
Looking at submissions to the Welsh testing site WEDINOS, samples bought as powder or crystal MDMA contained a range of compounds including previously legal NPS such as methylone, mephedrone and a-PVP, alongside cocaine, caffeine, speed and a host of other compounds.

There is no easy way for end users to assess pill strength, or the content of powders and crystals. The claimed strength of dark web retailers cannot be relied on, and as fast as 'genuine' pills are sold online, fake ones are likely to appear on the streets.

Other options for information include Erowid's Ecstasy Data (www.ecstasydata.org) the user-run Pill Report (pillreports.net) and WEDINOS, (www.wedinos.org) from Public Health Wales. Each carries useful information on components or user experience, but little on pill strengths.

Thanks to the efforts of The Loop (wearetheloop.org), club and festival pill testing has increased, and at a small but growing number of events it is now possible to have drugs tested and results passed back to users and health professionals in a short timeframe.

More info about MDMA at www.drinkanddrugsnews.com



Everynight Images / Alamy Stock Photo

HOUSE PARTIES AND TEDDY BEARS

The emergence of online and festival-based resources are welcomed. They are, however, most accessible to tech-savvy club and festival-goers who are interested in harm reduction and aware that they are taking MDMA.

Young people taking pills and attending house parties are at very high risk and fall outside these information channels. Pills are cheap, well-pressed, colourful and increasingly attractive with designs such as Instagram, Snapchat or teddy bears that inevitably resonate with younger people.

At £2-3 a pill (strong enough to share) it's cheaper than cider or a bag of weed, and teenagers may not associate this Molly, Mandy, E – or whatever the pill is called – with MDMA and the risks that it entails.

Incidents of young teenagers taking MDMA pills in atypical settings demonstrate why websites and festival testing need to be backed up by high quality education and awareness-raising. Young people at house parties, with no access to the festival or club welfare services, need to be equipped with the knowledge and skills to respond to MDMA-related incidents for themselves.

HARM REDUCTION

For young people contemplating use, key messages include general risks around strong stimulants and hallucinogens, especially in unfamiliar settings, and should include information about potency, overdose prevention and managing emergencies.

Crush – dab – wait has become a key message about starting with low doses of MDMA. Developed by the Loop, it is a field-appropriate method of taking a smaller drug dose on a moistened finger and waiting for one to two hours before taking further doses. In practice it can be hard to crush dense tablets in festival settings and if the drug in question is highly potent (such as a SCRA or a fentanyl) even dabbing could be a risk.

Starting with low tablet doses – quarter to half a tablet – will reduce risk, although a quarter of a tablet for a young user is still a potentially dangerous dose when tablet strengths are possibly 220mg+. In groups, one person taking a very low 'tester' dose can help reduce risk to the rest of the group.

ANXIETY AND PANIC are common especially for new users, so it is helpful to have more experienced, sober friends who can reassure and calm the person. As ever, set and setting matter, so using when feeling well in a familiar, safe environment is protective.

SEROTONIN SYNDROME, caused by excessively high levels of serotonin, could be caused by high doses of MDMA. Risk increases where other serotonin-elevating drugs are used, including some antidepressants, tramadol, some antihistamines and many other compounds. Indicators of serotonin syndrome include agitation, delusions, fast heart rate, elevated body temperature, muscle twitching, seizures and convulsions, and it can be fatal. Where serotonin syndrome is suspected, an ambulance should always be called.

CONVULSIONS: safe management of people convulsing means always calling an ambulance, allowing the person to convulse unrestrained, removing things in the vicinity that could cause injury where possible, and protecting but not restraining the head. Nothing should be placed in the mouth as it increases risk of choking.

OVERHEATING caused by elevated serotonin levels is highly dangerous. Chilling out from dancing and staying hydrated can help reduce the risk. If a person feels excessively hot, complains of feeling too hot, is panicked, complains of headaches, has excessive sweating, or conversely stops sweating, these could be indicators of overheating. Reduce body temperature by spraying their unclothed torso with tepid water, under moving air, but always seek medical help as overheating can lead to blood clotting and organ failure. Don't try to give the person cold drinks or immerse them in cold water.

HYDRATION AND OVER-HYDRATING: Excess water consumption, combined with MDMA's anti-diuretic properties, can cause water retention and in extreme cases can cause electrolyte imbalance and swelling of the brain. This can be life threatening. Advice remains to drink around a pint of water or an isotonic drink, sipped over the course of an hour, which helps maintain hydration but minimises risks of hyponatraemia.

SELF-CARE: MDMA use can lead to significant depletion of serotonin after use and can cause quite serious low mood and depression. Stress the importance of taking long breaks after use, eating well and avoiding other substance use.

Kevin Flemen runs the drugs education and training initiative, KFx.

Visit www.kfx.org.uk for free-to-download leaflets on ecstasy – Fest-E (about the wisdom of doing ecstasy for the first time at a festival) and First-E (guidance for first-time users). Both were produced by KFx in 2014 and illustrated by a 17-year-old, in response to growing concern about ecstasy.

New production methods and the massive marketplace that is the dark web have seen manufacturers competing on strength and price, so low cost is no longer indicative of a low-dosed pill.

A space to listen

Dual Diagnosis Anonymous is a new peer-led resource for people with co-existing mental health and addiction problems, as **Dr Raffaella Milani** explains

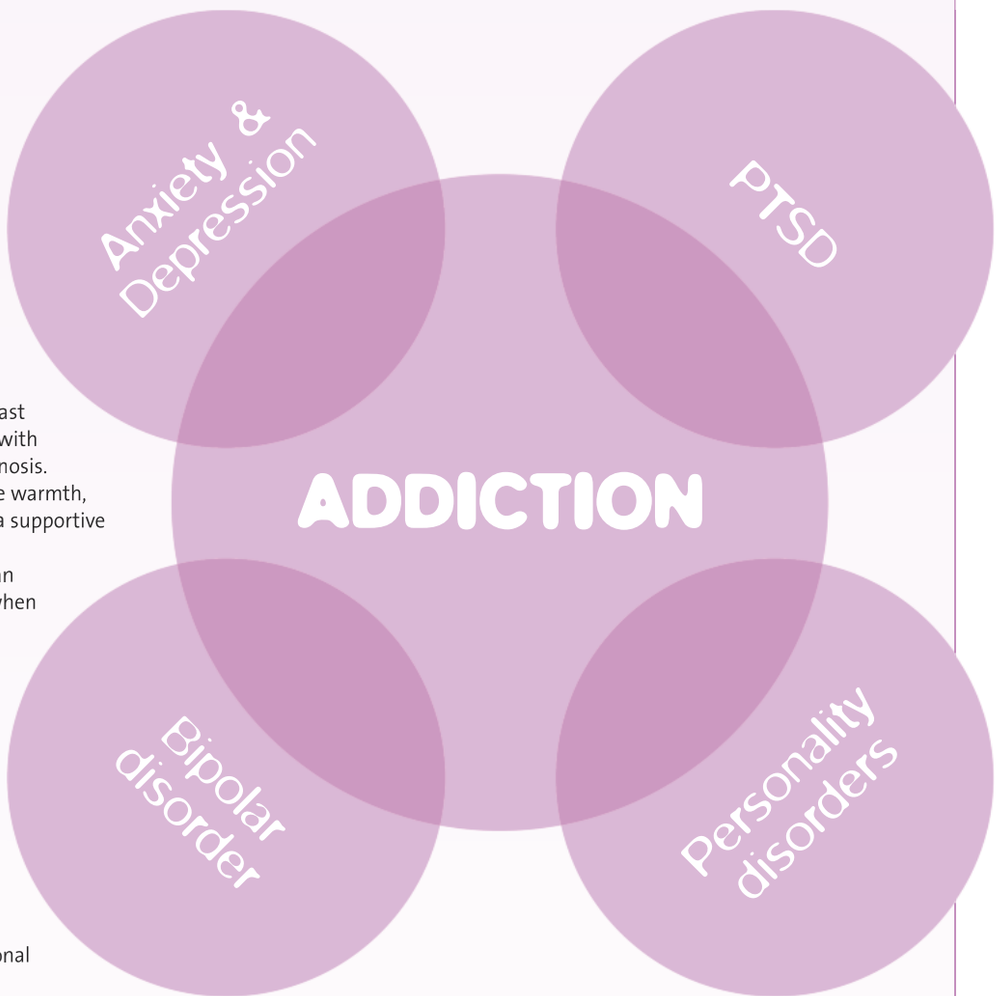
Coexisting substance misuse and mental health disorders (dual diagnosis) are the norm, rather than the exception. A report commissioned by the Department of Health and NTA in 2002 found that 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems, and 44 per cent of mental health service users either reported drug use or had used alcohol at hazardous or harmful levels in the past year (Weaver *et al*, 2002).

The Prison Reform Trust's 2010 *Bromley Briefing* reported that 75 per cent of all prisoners had a dual diagnosis, yet Lord Bradley's 2009 review of people with mental health problems or learning disabilities in the criminal justice system stated that those needing to access services for both mental health and substance misuse/alcohol problems were disadvantaged by the system. Furthermore, the 2016 national confidential inquiry into suicide and homicide by people with mental illness found that over the last 20 years, alcohol/drug misuse and isolation have become increasingly common factors as antecedents of suicide; more than half of the patients who died by suicide had a history of alcohol or drug misuse, but only a minority of patients were in contact with substance misuse services.

Despite the high prevalence of people with dual diagnosis and the associated negative consequences on the physical, psychological and social domains, there is a clear gap in the service delivery for these clients. Recovery is a long-term process, and for people with comorbidity it is a lifelong commitment. Non-judgmental attitude, integrated care, and a social network that supports abstinence are three key elements of successful and sustainable recovery. Mutual aid groups such as AA have been playing an important role in supporting individuals in achieving and maintaining abstinence in the UK and around the world, and are an invaluable source of social capital for those who are most at risk of isolation.

Since August 2016, a new peer-led resource has been made available in west London. It provides a non-judgmental, empathetic and welcoming environment

More on dual diagnosis at www.drinkanddrugsnews.com



where people with dual diagnosis can get their voice heard. Called Dual Diagnosis Anonymous (DDA), it is free, available in the community, does not require referral, there is no waiting list – and most importantly it adopts an integrated approach to comorbidity. The groups are facilitated with competence and compassion by John O'Donnell, a peer supporter with many years of experience in running groups.

DDA-UK was founded by Daniel Ware and Alan Butler, with the support of the Ealing Councils' commissioners for addictions, Ealing Council commissioning for mental health and the clinical commissioning group. Daniel discovered DDA in 2014 on a research trip to Portland, USA, where he was studying approaches to homelessness and support. Having worked for the last 13 years in frontline homeless services in London, he was familiar with the lack of specific services and support for those with a dual diagnosis.

'When I attended the US DDA meeting I was taken aback by the warmth, energy and positivity in the room,' he says. 'People were clearly in a supportive space which they could not find anywhere else.'

Daniel met DDA's founder Corbett Monica, a Vietnam vet and an experienced therapist, who was himself in recovery. It all started when two of Corbett's clients were politely asked not to return to a local AA meeting as they were 'too unwell'. In response, Corbett gained permission from AA and devised the 12 steps 'plus five'. The extra five steps related specifically to the mental health aspects of a dual diagnosis: acknowledging both illnesses, accepting help for both conditions, understanding the importance of a variety of interventions, combining illness self-management with peer supports and spirituality, and working the programme by helping others.

The programme also includes the Dual Diagnosis Anonymous workbook, which guides the reader through the 12 plus five steps with explanations and well thought-through reflective exercises. The meeting consists of a regular AA-style gathering and an additional non-compulsory facilitated workshop to go through the workbook.

The first time that I attended a DDA meeting I immediately sensed how people felt accepted and free to be themselves, whatever their mental health status at that moment in time. I was also surprised how diverse the group was, in terms of age, culture, gender, mental disorders and the addictive behaviours that members presented with.

During the meeting there were moments of shared sadness but a lot of laughs too. As the co-founder and peer supporter Alan Butler explains, 'When people attend meetings the first thing that becomes apparent is that they are hearing their own life experience echoed in the words of others. When you attend meetings you are advised to listen for the similarities – not the differences. In the traditional AA or NA fellowship people attempt to separate two inseparable conditions, for fear of judgment and not being accepted. Historically this is something dually diagnosed sufferers have been asked to do by the statutory services.

'DDA offers a place and space where individuals with comorbidity can finally be heard by those who identify with similar experiences,' he continued. They can talk of their personal struggles with addictive behaviours as well as of matters such as positive effects or side effects of medications, the hearing of voices, the clinical interventions, or their worries and anxieties. Identification is what keeps people attending self-help groups.'

'DDA offers a place and space where individuals with comorbidity can finally be heard by those who identify with similar experiences.'

The initial evaluation is very encouraging. One young DDA member who had been suffering from psychosis and cannabis misuse said that for the first time she could identify with other members in the group. She felt that cannabis was not considered to be problematic by members in traditional NA groups, while the DDA facilitator, other members and the workbook helped her understand how use could affect her mental health.

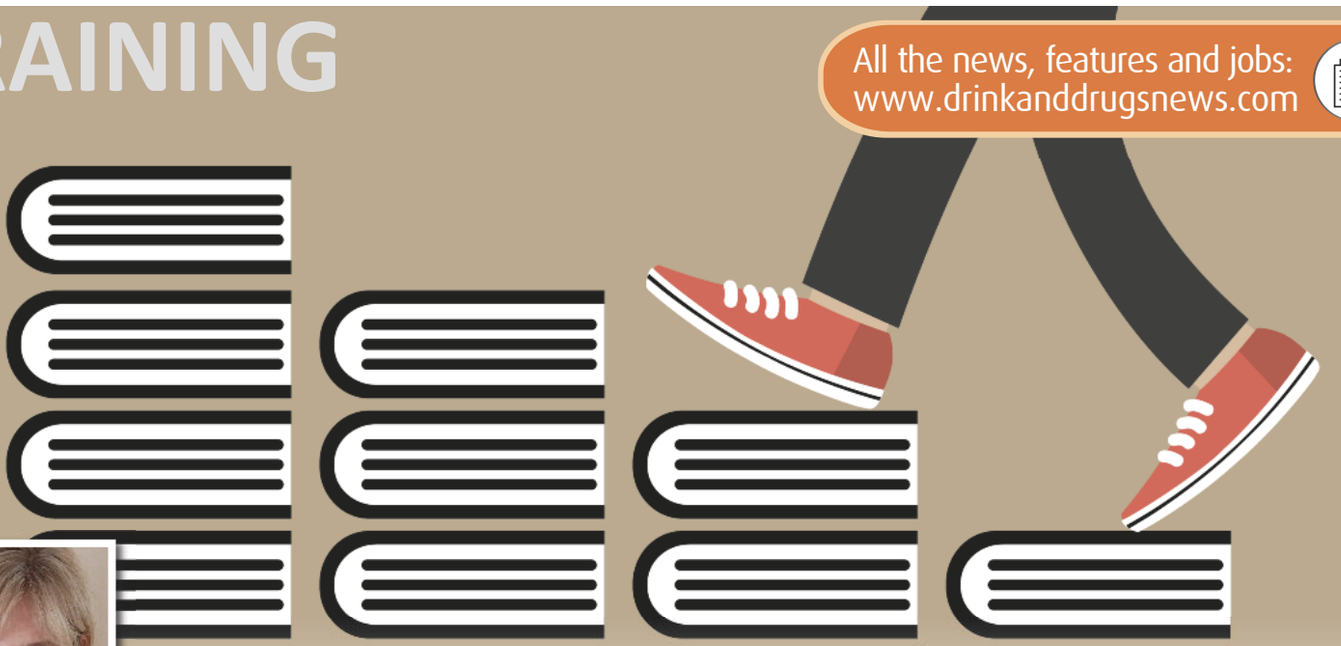
'I found the workbook and the workshops very helpful, I understand better what happened to me and I feel free to talk about my medication and how I feel,' she said. 'I have been able to stay clean for several months and I am doing very well with my studies... The difference in age doesn't bother me – I think that it's helpful to confer with people who have more experience than me. I also find that the facilitator is very competent and helps me understand what I'm going through.'

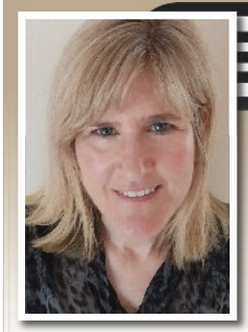
There are five meetings happening in London every week and they are inclusive and open to anyone who is interested in being alcohol/drug free. Family members and professionals who want to familiarise themselves with the programme are welcome too. The goal and the challenge now is to make the programme sustainable throughout London and the UK in the next few years.

Concluding with Alan's words, 'The fellowship of DDA is predicated upon hope – something that is voiced in the words penned by Fyodor Dostoevsky and adopted as our DDA motto: "To live without hope is to cease to live."'

Find out more at www.ddauk.org/programs

Dr Raffaella Milani is senior lecturer and course leader for substance use and misuse studies at the University of West London. More about the university's courses at: www.uwl.ac.uk/academic-schools/psychology/subject-areas-and-courses/substance-use-and-misuse





STEPPING UP

What do new apprenticeship rules mean for the drug and alcohol sector? **Kate Halliday** explains

From April 2017 all employers in England with a salary bill of more than £3m have been required by the government to pay an 'apprenticeship levy' amounting to 0.5 per cent of their payroll. That's a lot of money – 2.3bn annually for all employers in the UK. Employers are allowed to recoup or 'draw down' this money by putting their employees through apprenticeship courses.

So what does this mean for the drug and alcohol sector? In February this year SMMGP took over the membership and accreditation function of FDAP (the Federation of Drug and Alcohol Practitioners, formerly the Federation of Drug and Alcohol Professionals) and we have been picking up some understandable confusion from providers surrounding the apprenticeship agenda. Here are a few common misconceptions:

1. ***You have to employ apprentices to draw down on the money paid into the apprenticeship levy.*** *This is not the case. Existing staff or volunteers who are not apprentices can access apprenticeship courses to enhance their qualifications, up to degree level. In fact it is predicted that the majority of funds will be used on training the existing workforce.*
2. ***You have to draw down money you have paid into the levy within a year or you lose it.*** *This is not the case – you have two years from initial payment to do this.*
3. ***I'm a small employer so the apprenticeship agenda does not apply to me.*** *This is not the case. There are generous incentives (up to 100 per cent of course fees covered) for smaller employers putting employees and volunteers through courses.*

CHALLENGES AND OPPORTUNITIES

Currently drug and alcohol service providers who are using the levy are choosing existing courses in non-sector specific qualifications (for example in management or generic counselling skills qualifications) as there is no specific apprenticeship qualification for people working in the drug and alcohol sector. But there are only so many staff for whom non-sector-specific qualifications are appropriate and many employers fear they will not be able to use the levy to upskill staff across the organisation. However, this may be about to change. In July a 'trailblazer' meeting is being held by employers in the field, which could mark the beginning of a sector-specific qualification.

> There is an opportunity to set the educational standard... at a higher level than is currently the case, and provide consistency throughout services.

Apprenticeship qualifications must be based upon a job role or title. Two possible suggestions for the field are drug and alcohol treatment worker and drug and alcohol treatment manager. The trailblazer group will be tasked with producing a standard for the job role/s identified, and this will need to capture evidence in three areas: knowledge, competency and behaviours.

The trailblazer process opens up the opportunity to set a consistent standard, agreed by employers, for job roles within the sector – something that has been missing until now. This has the potential to provide consistency for employers, commissioners, the workforce and users of services. It is likely to involve the reassessment of DANOS standards (widely seen as appropriate for the field but perhaps in need of some updating) and will require agreement on the level of educational attainment required to carry out the job – something that has not been consistent throughout the field. Once the standard is set, educational providers can develop courses to meet the needs identified in the standard. This could happen relatively quickly (within a year) allowing employers to begin to draw down on the money paid in over the current year.

There are some challenges: anyone studying for apprenticeship qualifications will be required to spend 20 per cent of their time studying. At a time when providers are being asked to provide 'more for less' there are concerns that this could place strain on service delivery. And while everyone wants to have the best possibly educated workforce, there are concerns about the financial envelopes commissioners are providing for service delivery and whether well-qualified staff can be appropriately remunerated.

The potential benefits of apprenticeships are numerous. They offer real opportunities for career progression and improved staff retention: volunteers, often people in recovery, can move from unpaid positions into employment supported by qualifications and in-work experience. People already working in the field can obtain qualifications that can support their current work and could lead to promotion. There is an opportunity to set the educational standard for those working in the field at a higher level than is currently the case, and provide consistency throughout services. And a workforce that is better trained will provide a better service for those in treatment.

Kate Halliday is FDAP interim executive director

For more information on apprenticeships including the trailblazer process watch a recording of FDAP's webinar at https://youtu.be/6S3ob6HNBJg

Are you an employer who would like to be involved in the trailblazing process? Contact Kate at fdap@smmgp.org.uk

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, Romney House, School Road, Ashford, Kent TN27 0LT. Letters may be edited for space or clarity.

'By engaging with clients over a long period and putting a support package together that includes OST at the right levels, clients are given the best possible chance of success'

DYNAMIC OUTREACH

Thank you for the article looking at outreach services in Brighton (Vital Connections, *DDN*, June, page 6). I would like to congratulate the team at Equinox for encouraging the 'entrepreneurial element to being a frontline worker'. As services increasingly implement more rigid working practices and set protocols for their staff, it was great to hear that their team were given the autonomy to deal with clients as individuals and take time to build their trust.

By engaging with clients over a long period and putting a support package together that includes OST at the right levels, clients are given the best possible chance of success when the time is right for them to enter rehab.

The 'whole person' vision with harm reduction working alongside recovery sounded refreshingly old fashioned in these days of targets and outcome data. Well done *DDN* for sharing this and many other examples of good practice from around the country. Keep up the good work!

Jack Bounds, by email

LET'S CONNECT!

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

IN RESPONSE TO 'MARKET FORCES' (DDN, JUNE, PAGE 14)

Bravo @KarenLTyrell in @DDNMagazine this month. '...keep people alive. Be as aspirational as you want, but keep people alive.'

Also @Shapiroharry spot on in same @DDNMagazinearticle when he says we need to bring #harmreductionback into the heart of the mainstream.

George Burton,@DoctorDimmage, by Twitter

It's no surprise with the funding cuts. Too many services have closed or had to reduce what they can offer.

Helen Morris Jenkins, by Facebook

Look to the Portugal model, radical and yet effective!

Amanda Thomas, by Facebook

With alcohol and drug contracts being awarded to the lowest bidders in austerity Britain, it's the commissioners who need to be challenged.

It's they who have blood on their hands thinking that alcohol and drug work can be done on the cheap. Deaths in service, especially in our larger cities... are truly staggering and alarming.

I hope deaths in service are truly transparent... Hopefully the CQC will leave no stone unturned in their visits... in examination and cross-checking of GP records of the deceased.

John Rogers, by Facebook

IN RESPONSE TO 'MEET THE FENTANYLS' (DDN, JUNE, PAGE 8)

Great article from @KFxNews on Fentanyls in latest @DDNMagazine

Andy Maddison, @andyinhaler, by Twitter

It's worth noting that as no chiral synthesis of 3MF exists and all isomers are active, it's most likely to be around x2800 morphine.

When it comes to these highly potent analogues, the actual potency becomes hard to gauge. A single report on 3MF stated that 0.016mg was active BUT the response to these super-potent analogues is variable between people. Just because someone else shoots a bag and is OK doesn't mean it can be presumed safe for others... even if someone DID cut it properly.

S W Dunlevy, by Facebook

IN RESPONSE TO 'ON BORROWED TIME' (DDN, MAY, PAGE 6)

Must read: @DDNMagazine May edition pages 6&7 about the crisis in the drug and alcohol sector. Deeply worrying.

SMMGP, @SMMGP, by Twitter

IN RESPONSE TO 'ALCOHOL-RELATED DEATHS MORE THAN 50 PER CENT HIGHER IN SCOTLAND' (ONLINE NEWS STORY)

I fear that increasing the price will yield the same results as tobacco – smuggling becomes widespread. What is even worse is that smuggled alcohol with be in the form of spirits.

Especially in the case of white spirits, the distilled product is over 90 per cent alcohol which is then diluted with (usually) spring water. A 2 litre 7Up bottle full makes six x 750ml of 40 per cent vodka.

I know the above because decades ago, Irish friends would bring in Poitín and diluted it, as I have described.

Of course, we don't know just how much untaxed spirits are being produced in the UK. I certainly remember that five people died in an explosion in an ad hoc distillery.

S W Dunlevy, by Facebook

It's a case of the corporations putting wealth before human life.

Alec Binman Hallwood, by Facebook

AND FINALLY...

As alcohol is the cause of Britain's biggest drug problem, why doesn't *DDN* refer to 'alcohol and illegal drugs?'

John D Beasley, London (by post)

/DDNMagazine @DDNMagazine
www.drinkanddrugsnews.com