DRINK AND DRUGS NEWS ISSN 1755-6236 NOVEMBER 2017

DDN

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HAS COMMISSIONING BECOME A RACE TO THE BOTTOM?

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EDITOR'S LETTER

'It's unsurprising that staff are feeling demotivated'

A commissioner said to me this week, 'We need to know what the evidence is, see good practice, do things like the service user conference. And we need to get the right information out there – like in your magazine – so people can say "oh that's an interesting, exciting idea".'

I had been focusing on a crisis in the sector, as we all do when faced with the unpalatable truth of worsening DRD statistics and fewer resources. But it made me think that there's a lot of mileage in partnership working – a phrase so well used that we're apt to ignore it.

Our cover story (page 6) shows that the glue that holds together successful partnerships is missing in many areas. The pressure of having to do much more with much less can have a damning effect on the imagination and it's unsurprising that staff are driven into feeling defensive and demotivated. Providers obviously play a central role in turning this around – but is this possible if they're focused on survival? If the support networks – and the hours in the day – are not there to help them work constructively with commissioners, how is this achievable?

Caroline Cole suggests responding to the challenges by borrowing from the corporate world (page 16), while Robert Mee draws on his personal experience to share how he created his support network for the LGBT+ community on page 12.
And finally, on page 10 we share resources to put this year's Alcohol Awareness Week campaign into action.

Claire Brown, editor

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

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Website: www.drinkanddrugsnews.com
Website support by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by Alexander Fagaulin/iStock

DDN is an independent publication, entirely funded by advertising.

Supporting organisations:

Release – Drugs, the Law & Human Rights

ANSA

Adfam – Families, drugs and alcohol

Alcohol Concern – Promoting health; improving lives

SMMGP – Substance Misuse Management in General Practice

WELSH GOVERNMENT MOVES TO INTRODUCE MINIMUM PRICING

A NEW WELSH GOVERNMENT BILL aims to establish a minimum unit price for alcohol and make it an offence for any alcohol to be supplied below it. The Public Health (Minimum Price for Alcohol) (Wales) Bill, which has been introduced before the National Assembly for Wales by public health minister Rebecca Evans, will address 'longstanding and specific concerns' around excess drinking, the government says.

The annual number of alcohol-related hospital admissions in Wales is estimated at 50,000, at a cost to the NHS of £120m. If a 50p minimum price were to be introduced, reductions in alcohol-related ill health, crime and lost productivity would be worth £882m to the country's economy over the next 20 years, the government claims, and there would be 1,400 fewer annual hospital admissions.

Plans by the Scottish Government to introduce minimum pricing have been mired in legal difficulties since the start of the decade, however. Although the Alcohol Minimum Pricing Bill was passed 18 months after a previous alcohol bill had its provisions for minimum pricing removed (*DDN*, June 2012, page 4), still-unresolved legal challenges from drinks industry bodies mean the legislation is yet to be implemented (*DDN*, December 2016, page 4). David Cameron's coalition government, meanwhile, shelved its plans to introduce minimum pricing on the grounds that there was 'insufficient evidence' that it would reduce harm without penalising moderate drinkers (*DDN*, August 2013, page 4).

The impact on moderate consumers in Wales would be small, the country's chief medical officer, Dr Frank Atherton, has stated, with the most impact falling on 'harmful and hazardous' drinkers.

'Alcohol-related harm is a significant public health problem in Wales,' said Rebecca Evans. 'The 463 alcohol-attributable deaths in 2015 were all avoidable, and each of these deaths would have had a devastating effect on the person's family and friends. Alcohol-related harm also has a big impact on public services such as the NHS. There is a very clear and direct link between levels of excessive drinking and the availability of cheap alcohol. So we need to take decisive action now to address the affordability of alcohol, as part of wider efforts to tackle alcohol-related harm.' The bill would put prevention and early intervention at the heart of efforts to reduce harm, she continued. 'This will undoubtedly help save lives.'

'There is a very clear and direct link between levels of excessive drinking and the availability of cheap alcohol'

REBECCA EVANS

Following the bill's introduction a letter signed by representatives of leading health organisations 'unequivocally' endorsing it – and calling for the UK government to follow suit – was published in the *Guardian*. Implementing minimum pricing would 'save lives, relieve pressure on our NHS and fulfil [the government's] commitment to even out life chances', it said. Among the signatories were representatives of the royal colleges of nursing, psychiatrists and general practitioners, the BMA, the Faculty of Public Health and the Royal Society for Public Health.

WASTED CHANCES

PRISONERS ARE EXPERIENCING A 'CLIFF EDGE' of little or no professional support in the weeks before and after release, says a report from the University of York, with many also housed in 'inappropriate' accommodation where drugs and prostitution are rife. Although some pilot drug recovery wings offer 'promising approaches', the efforts of dedicated staff are likely to 'come to naught' on release, warns *Evaluation of the drug recovery wing pilots*. 'We have to ask ourselves whether any of us could make any radical changes to our lives if we were forced to live in the type of environments many of our ex-prisoner interviewees had to live in on release,' said principal investigator Charlie Lloyd.

Report at www.york.ac.uk

POLICE PULLBACK

PHILIPPINE PRESIDENT RODRIGO DUTERTE has removed the country's police force from its lead role in his violent crackdown on drugs, the Philippine government has announced. The lead body will now be the Philippine Drug Enforcement Agency (PDEA), with the police, armed forces and 'ad hoc anti-drug task forces' instructed to leave it as the sole agency in all anti-drug operations. Duterte previously suspended the crackdown in order to address problems of police corruption after a Korean businessman was allegedly murdered on police premises (*DDN*, February, page 5), and there were widespread protests this summer, as well as condemnation by the country's powerful Catholic Church, after an unarmed 17-year-old student was shot dead by police.

STRATEGY SESSIONS

A SERIES OF EVENTS to 'promote the opportunities' of the 2017 drug strategy and revised clinical guidelines (*DDN*, September, page 17) has been organised by the Home Office, Collective Voice and the NHS Substance Misuse Provider Alliance. The sessions, which will be held in Halifax, Birmingham and London in the second half of November, will also cover mental health and substance misuse as well as drug-related deaths.

Email alison@collectivevoice.org.uk

DARK DAYS

THE UK IS RESPONSIBLE for almost 10 per cent of global 'darknet' sales of fentanyl – making it the largest seller in Europe – according to the Oxford Internet Institute's 'darknet mapping project'. The US accounts for almost 40 per cent of global trade, followed by Canada and Australia at 15 and 12 per cent. While China is responsible for just 4 per cent of sales, this doesn't necessarily mean that China is not the 'ultimate site of production', the researchers stress, as many western sellers are more likely to be intermediaries than producers. The UK saw more than 60 deaths related to fentanyl or its analogues in the first eight months of 2017 alone (*DDN*, September, page 4).

Project details at www.oii.ox.ac.uk/research/projects/economic-geog-darknet

NALOXONE NEWS

MARTINDALE PHARMA has notified people in receipt of Prenoxad Injection kits, as well as those involved in their supply, of a temporary change in the labelling to address an historical error. Prenoxad Injection is a pre-filled syringe containing naloxone hydrochloride solution, and was the first naloxone product to be licensed for use by non-healthcare professionals in a community setting. While the labelling now shows the strength as 0.91mg/ml rather than 1mg/ml, letters have been sent to users, professionals and non-medical practitioners stressing that there is no difference to the amount of active ingredient and no additional safety concerns.

More information at www.medicines.org.uk/emc/medicine/27616 and www.medicines.org.uk/emc/medicine/34154

TRUMP DECLARES OPIOID CRISIS 'A PUBLIC HEALTH EMERGENCY'

US PRESIDENT DONALD TRUMP has declared the country's opioid crisis a 'nationwide public health emergency' and said that he is 'mobilising his entire administration' to address the situation, the White House has announced.

Last year more than 2m Americans had an addiction to illicit or prescription opioids, with drug overdoses now the leading cause of 'injury death' in the US, outnumbering both traffic and gun fatalities. There were more than 52,000 drug overdose deaths in 2015, with the White House expecting 2016's total to exceed 64,000 – a rate of 175 deaths per day.

In 2016 more than 11.5m Americans reported misuse of prescription opioids and 950,000 reported heroin use, the administration says, with the rising death rate in part the result of 'the proliferation of illegally made fentanyl'. An interim report from the President's Commission on Combating Drug Addiction and the Opioid Crisis urged him to declare a national emergency earlier this year (*DDN*, September, page 5).

The emergency declaration will allow expanded access to substance misuse treatment and medication, including for people in HIV/Aids programmes, as well as the recruitment of more treatment professionals and provision of grants for people who have been 'displaced from the workforce' as a result of addiction. 'Ending the epidemic will require mobilisation of government, local communities, and private organisations,' said Trump. 'It will require the resolve of our entire country. I am directing all executive agencies to use every appropriate emergency authority to fight the opioid crisis. This marks a critical step in confronting the extraordinary challenge that we face.'

The US-based Drug Policy Alliance, however, accused the president of 'ignoring reality' and 'sticking his head in the sand'. 'While a couple of his proposals might help mitigate overdose, his speech revealed a profound and reckless disregard for the realities about drugs and drug use in the United States,' said alliance director Maria McFarland Sánchez-Moreno.

'Trump seemed to be saying that prevention boils down to ads encouraging young people to "just say no" to drugs, ignoring the utter failure of that strategy when the Reagan administration started it in the 1980s,' she continued. 'And he continued talking about criminal justice answers to a public health problem, even though the war on drugs is itself a major factor contributing to the overdose crisis. Trump had a chance to do something meaningful to help stem the tide of overdose deaths in the country – instead, he is condemning even more people to death, imprisonment, and deportation in the name of his war on drugs.'

'Criminal justice answers to a public health problem.'

A position paper from the Global Commission on Drug Policy has also urged that supplies of prescription opioids should not be cut without 'first putting supporting measures in place'. Harm reduction options need to be expanded, alongside 'de facto decriminalisation' of possession and personal use, says *The opioid crisis in North America*. The extent of the public health crisis 'cannot be overstated', it warns.

Position paper at www.globalcommissionondrugs.org

PARENTAL PROBLEMS

PARENTS DO NOT HAVE TO REGULARLY DRINK LARGE AMOUNTS for their children to 'notice changes in their behaviour and experience negative impacts', according an Institute of Alcohol Studies (IAS) report. Having seen a parent 'tipsy or drunk' was associated with children feeling worried, 'less comforted than usual', or experiencing more arguments, says *'Like sugar for adults': the effect of non-dependent parental drinking on children and families*. Nearly 30 per cent of parents reported having been drunk in front of their children, while more than 10 per cent of children said they'd felt worried or that their parents had given them less attention as a result of drinking. Meanwhile, a report by the University at Buffalo's research institute on addictions found that children of parents with an alcohol use disorder were more likely to be involved in 'abusive dating relationships' as teenagers.

Reports at www.ias.org.uk and www.buffalo.edu

WELSH WORRIES

COCAINE-RELATED HOSPITAL ADMISSIONS in Wales have risen by more than 80 per cent in the last five years, according to figures from Public Health Wales. Admissions for cannabis and synthetic cannabinoids are also up more than 70 per cent, although overall admissions for alcohol and drug use among young people are declining. The figures highlighted 'big changes' in patterns of use, said head of the agency's substance misuse programme, Josie Smith. 'The increase in harms associated with cannabis and cannabinoids are particularly challenging to interpret. This is in large part due to the growth in the use of synthetic cannabinoid receptor agonists including 'spice'.' *The annual profile for substance misuse 2016-17 at www.wales.nhs.uk*

BETS ARE OFF

THE GOVERNMENT HAS ANNOUNCED that it intends to reduce the maximum stakes allowed on Fixed Odds Betting Terminals (FOBTs) as part of its gambling review. Known as the 'crack cocaine of gambling' (*DDN*, September 2014, page 6), the controversial machines currently allow users to bet up to £100 a time. The government will now consult on cutting the stakes to as little as £2, while other measures include stricter advertising guidelines and revised codes of practice for online gambling. 'Given the strong evidence and public concerns about the risks of high stakes gaming machines on the high street, we are convinced of the need for action,' said gambling minister Tracey Crouch. *Consultation at www.gov.uk until 23 Jan.*

TIMELY INTERVENTIONS

THE FIRST FOUR WEEKS OF TREATMENT, as well as the first four after leaving it, are 'critical intervention points to reduce mortality risk', says an NHS Health Scotland evidence review on drug-related deaths. Complex psychological and social barriers also need to be addressed to support people to access services, it stresses. *Drugs-related deaths rapid evidence review: keeping people safe at www.healthscotland.scot* *See news focus, page 9.*

COST CALCULATIONS

A NEW EMCDDA REPORT attempts to fill the 'data gap' on the costs of drug treatment, with an overview of the economic models used to estimate expenditure worldwide. 'In this economic climate, more than ever, policymakers and service planners require data and information on the capacity, performance and costs of national treatment systems in order to support investment decisions and to make sound policy choices,' said EMCDDA director Alexis Goosdeel. The centre has also issued a guide to responding to specific drug issues such as older users, fentanyls, and harm reduction in clubs and festivals. *Drug treatment expenditure: a methodological overview and Health and social responses to drug problems at www.emcdda.europa.eu*

Data and information needed now 'more than ever'.
ALEXIS GOOSDEEL

COMMISSIONING

'Such is the cut-throat climate of retendering that treatment agencies are paring their tenders to the bone – or walking away from areas where they just can't make the funding work…'

More on procurement at:
www.drinkanddrugsnews.com

What's the name of the game?

Has commissioning lost its way – or are there opportunities to be grasped? DDN reports

The commissioning structure needs an overhaul, according to the ACMD Recovery Committee, which recently advised government of the drastic effects of funding cuts (*DDN*, October, page 4). Since commissioning was moved to public health structures in local authorities in 2013, there have been dramatic reductions in local funding that 'are the single biggest threat to drug misuse treatment recovery outcomes', says their report, *Commissioning impact on drug treatment*.

The stark truth for the treatment sector, ACMD Recovery Committee, service user representatives and many commissioners themselves is that the level of disinvestment is causing drug-related deaths. 'The loss of funding is resulting in drug-related deaths, blood-borne viruses, crime and human misery,' the committee's chair, Annette Dale-Perera told the Drugs, Alcohol and Justice Cross-Party Parliamentary Group.

Gathering evidence for the report brought strong evidence of an overall reduction in funding of around 12 per cent, she added. 'There was a definite decrease when money went over to local authorities. But many commissioners and providers told of cuts that were more severe than shown.' *DDN* is hearing of cuts of up to 30 per cent in some areas.

The situation is no surprise. Blenheim chief executive John Jolly said at the latest meeting of the parliamentary group, 'I take no joy in arriving where I said we'd be five years ago, when everyone said I was shroud waving.' The difference now is that it's being felt all over the country and the effects are critical – on service users' lives and on the skillset of a sector whose workforce are voting with their feet at having their wages cut and their roles merged and changed beyond recognition.

Current commissioning practice is taking much of the blame for the disastrous slide into chaos being felt by the sector. Such is the cut-throat climate of retendering that treatment agencies are paring their tenders to the bone – or walking away from areas where they just can't make the funding work. Bristol City Council received no bids from service providers when attempting to retender drug and alcohol support services recently, with feedback that the money offered was just too low.

Those that have 'gone for it' at any price find themselves tethered to uneconomic contracts with the risk of harsh 'payment by results' penalties and financial liabilities that come with TUPE arrangements for transferring staff. The sector is still shuddering from the recent demise of Lifeline and speculating on a toxic mix of contributing factors. Many are angry that their winning bid helped to drive tender prices down to a dangerous new low and blame the commissioning team for exacerbating a 'race to the bottom' culture.

Jolly is among the providers who recognise that local authorities are 'between a rock and a hard place', with dwindling budgets and some difficult choices to make: 'do you spend on substance misuse, or do you spend on social care for the elderly? They're in a difficult space.' Blenheim is on the commissioning rollercoaster with everyone else, having to remodel services to try and fit new specifications. The experience of working for decades in a neighbourhood suddenly counts for very little against shaving a third off the contract price. There's no getting away from the fact you have to do much more with fewer resources.

The loss of expertise is one of the many things that bothers him. Gone are the days of specialist services for different substances. Everything – including alcohol, cocaine and stimulants, which would have had specific services a short time ago – is combined into the same service, which 'can be a problem if people don't see that it's for people like them'. Young people's drug services are no longer standalone, but combined with sexual health services.

This contraction of services has meant a cut in the skilled workforce, which does not match well with a depressed economic climate and emergence of new drug trends – young people are returning to opiate use after a generation away, and the growing threat of more fentanyl deaths looms. Drug and alcohol use accompanies deprivation all too readily, and street homelessness is commonplace. 'In every major city now, you're seeing street homelessness in a way that we've not seen for a decade, maybe 20 years,' says Jolly.

Furthermore, the cuts mean people who use services are often couch surfing, in hostels, or living rough, he explains, and 'many of them are returning to opiate use because they've got absolutely nothing to lose'.

Bill (not his real name) is a drugs worker who is being transferred from one service provider to another, as part of retendering. He blames the last round of tendering for bringing an assortment of providers together to create a system that did not work.

'By the end of the process, what you've got is a complete history of poor key-working, inappropriate allocation, poor assessment and a situation where the top staff, who had come over from the NHS or previous places, had been replaced by kids without any real experience or qualification,' he says.

He describes how it felt to be caught in the middle of the process. 'Since the tendering process began, there was an exaggerated bonhomie about the success of partnership working, which was unrealistic,' he said. 'There was some fairly desperate grabbing of intellectual property, which was grubby, and there was a real sense of isolation for the individuals involved in the process. And for people in active recovery, people in the community, there was a sudden loss of the security they'd built up in those five years.'

Most disturbingly, 'in the six months after we announced the contract was lost, we had about a 40 per cent relapse rate among service users and a huge drop in engagement,' he says. 'So it's been devastating on the community and devastating on individuals.'

He believes that the cost-cutting led to cutting corners with staff training and development and a dismissive attitude towards peer support. Assessments of new clients were conducted through a deficit-based approach – 'when did you last commit acquisitive crime?', 'when were you last a sex worker?', rather than an

asset-based assessment with scope for 'holistic solutions from the get-go'. His service has lost its way, he believes, and the ability to see that 'prescribing isn't anything but a tool. It isn't a raison d'être'.

Bill is also worried that this blinkered culture is making the workforce slow to react to trends and the 'constant shift in the way people are doing drugs'. The commissioning process has brought the focus away from specialist services based on the needs of the area; so it doesn't, for instance, allow for the fact that solvent abuse has soared during the past five years, or that staff have come across 'strange behaviours and violent reactions' among cocaine users that has left staff wondering if investigation is needed into what they are actually taking.

Such matters became absorbed in the business of jobs being reassessed, and staff being asked to take on more responsibilities for the same money. Bill thinks staff no longer have the time or the vision to understand that in so many cases, substances are the least of their clients' problems.

'It doesn't matter what commissioning process is happening if somebody has got no house, no benefits, no transport, no food, no friends,' he says. 'We're working in the age of isolation, and every single person I work with now has got multiple complex needs.' He worries that 'things have to get really bad before they start to get any better', adding 'many of the good workers have already walked away... If we have many more cuts, I don't know where we'll go really.'

'I've been a provider myself – I can believe that there are bad things that happen out there,' says Sarah Hart, senior commissioner at Haringey. But despite the very obvious challenges, she does see many opportunities with the move into public health at the council.

'It lets me meet more partners around the table,' she says, describing her work on improving life expectancy, bringing health checks and interventions for long-term conditions to hard-to-reach groups and 'further integrating substance misuse into broader public health'.

As far as the money is concerned, 'the important thing is to have commissioners who ensure that substance misuse services don't get disproportionately affected' – which she acknowledges is difficult when those who use council services are likely to be economically disadvantaged.

One of her main challenges is to keep community safety colleagues on board, she says, 'because as we know, it was the crime that got the money'. The 33 per cent cut in MOPAC grants (money provided by the Mayor's Office for Policing and Crime) has led to some particularly tough decisions, pitting the value of the Drug Intervention Programme (DIP) against services to tackle gang culture, and violence against women and girls.

Another difficulty has been having less time than before to work with providers, 'particularly if a provider is struggling'. Gone are the days of specialist commissioners holding provider meetings to look at best practice – and gone are the days also when larger commissioning teams could work strategically with partners in probation and housing. There are no longer even the youth leads to work with schools.

It's become more important for providers to showcase what they're doing, feeding evidence of their work to commissioners, 'so they become passionate about substance misuse', she says. Having come into commissioning via the substance misuse worker route she needs no convincing, but is aware that in many areas providers will need to 'win hearts and minds' of their commissioners.

The campaign for longer commissioning cycles makes her wary of leaving systems in place that no longer work for clients. 'Change is difficult in organisations and tendering justifies organisations constantly reviewing what they're doing and what they're delivering,' she says. 'We get complacent and our clients change. We constantly need to be saying, "is our service right? Is it fit for purpose?" And I'm not sure that without a tender process people would do that.'

The suggestion of a ten-year contract certainly does not appeal. 'Would a specification that I'd written ten years ago still be relevant? It would say nothing about club drugs, legal highs, over the counter medication. It wouldn't have anything about recovery in it.' But she supports the idea of longer tenders with a break clause. 'I've just done a five-year tender – three years plus two. And why it matters is that at the "plus two" stage, the service redesigned itself. If it had been a ten-year contract they might have waited seven years to go "well actually, it's not quite working".'

She believes that, as with everything in the sector, it's about balance – and about recognising that substance misuse services really matter: 'This isn't about buying paper, this is about services that people value highly and they get very very frightened when those services are being changed.' And the welfare of the sector going forward will depend on better partnership working, she says, and a willingness to showcase the work of good providers and organisations – those who add social value.

To fellow commissioners, she suggests: 'You may well have a provider that's been in an area a long time and creates jobs and does a lot of extra things in the community – lets people use its buildings, supports homeless charities. It's about trying to draw that out when you're tendering, scoring, and evaluating.'

And to providers worried about the 'race to the bottom' in stripping a service bare to compete for a tender, she says: 'I've been a provider, and I would say if there's not enough money in the tender, don't bid for it. It's the thing that commissioners most fear, that no one will bid for their tender – but don't bid against each other.' **DDN**

In a nutshell...

The ACMD Recovery Committee has made the following conclusions and recommendations in its review of commissioning:

LOSS OF FUNDING IS THREATENING RECOVERY OUTCOMES

Funding should be protected by mandating drug and alcohol services within local authority budgets or including treatment in NHS commissioning structures. Government needs to review key performance indicators to ensure quality of treatment.

LACK OF MONEY IS COMPROMISING TREATMENT QUALITY

National bodies should develop clear standards. The government's new Drug Strategy Implementation Board should ask PHE and the Care Quality Commission to lead a review of the drug misuse treatment workforce to achieve a balance of qualified staff.

DRUG MISUSE TREATMENT IS DISCONNECTED FROM OTHER HEALTH STRUCTURES

Local and national government should strengthen links between local health systems and drug misuse treatment, and include it in clinical commissioning group planning.

FREQUENT REPROCUREMENT IS COSTLY AND DISRUPTIVE

Commissioners should ensure recommissioning drug treatment services is normally undertaken in five to ten year cycles. PHE and the Local Government Association need to support local authorities to avoid unnecessary reprocurement.

CURRENT COMMISSIONING PRACTICE IS UNDERMINING RESEARCH

The new Drug Strategy Implementation Board should include government departments, research bodies and other stakeholders in building effective infrastructure for research.

From the ACMD Recovery Committee's report, Commissioning impact on drug treatment, at www.gov.uk

PLAYING FOR KEEPS

With Scotland experiencing ever-higher numbers of drug deaths, its government is developing a strategy to keep vulnerable older users in treatment. DDN reports

This summer Scotland once again broke its own bleak record by registering its highest ever number of drug-related deaths (*DDN*, September, page 4). The 867 fatalities were more than double the figure from a decade ago and make Scotland's drug-related mortality rate the highest in the EU.

With the median age 41, and nearly a third of the deaths in the Greater Glasgow and Clyde NHS board area, the twin problems of deprivation and an aging cohort of entrenched users are looking more acute than ever. The Scottish Government has since announced an extra £20m funding for treatment as well as an 'overhaul' of its drugs strategy (*DDN*, October, page 4). It's also developing a framework to engage older users and keep them in treatment, called 'Seek, Keep and Treat', as part of which NHS Health Scotland has issued a new report, *Drugs-related deaths rapid evidence: keeping people safe* (see news, page 5).

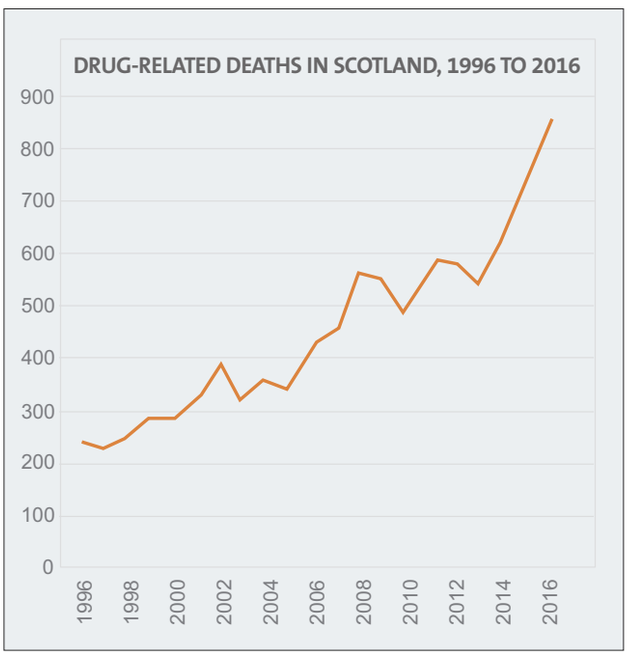
'If you look back over the last 20 years, all of the increases in fatal overdoses have been in the over-35s,' Scottish Drugs Forum CEO David Liddell – whose organisation is helping with the 'Seek, Keep and Treat' strategy – tells *DDN*. 'The under 35 deaths have remained fairly static.'

More than 120 current injectors or people who had injected in the last six months were interviewed for SDF's expert working group report, *Older people with drug problems in Scotland* (*DDN*, July/August, page 4), with an average age of 41. 'So a very similar profile to those who are dying,' says Liddell. 'What we found was that they weren't being held in services and, alongside that, 79 per cent were living alone. There were massive issues of anxiety and depression, all these underlying health issues that weren't being addressed, housing issues, welfare benefits issues. So the "keep" part of the initiative is very much about ORT and recognising the protective factors of keeping people in treatment.'

While some countries have up to 80 per cent of problem drug users in treatment at any time – and with that treatment sustained over the long term – Scotland's current rate is around half that. 'I think there's an increasing recognition of the need to hold more of that older population in treatment and maybe try to integrate those other health issues, like COPD, within addiction services,' he says.

'Underlying health issues aren't being addressed, housing issues, welfare benefits issues...'
DAVID LIDDELL

Another issue can be the power relationship between users and those ORT services, he points out. 'I think advocacy is very important for this population to help sustain contact, but also to help them navigate their way through and better assert what their needs are. In too many cases the individual has to fit the service on offer, rather than the other way round. So while we obviously need to put back some of the core funding to services, we also need to look at how that money might potentially be used to change practice on the ground.



'When you've got a service for 3,000 people it's very hard to deliver the person-centred care,' he continues. 'A key part would be that someone is seen by the same person every time to build up a therapeutic relationship. I think there's broadly a consensus that things have to change, but in terms of the very big services it can be difficult to turn things around. So there are questions about how the new investment is used, and how you then deliver change.'

The *Keeping people safe* report stresses the effectiveness of harm reduction interventions, and plans for a consumption room in Glasgow appear to be nearing fruition (*DDN*, July/August, page 4). A key part of addressing individual need is looking at prescribing options, Liddell stresses – 'matching the substance to the individual' – and the facility aims to offer heroin-assisted treatment. Is he confident it will happen?

'I think the heroin-assisted treatment part is probably easier to deliver in terms of legality issues and so on – I'd be very optimistic that it will happen,' he says. 'There's a consensus in Glasgow that heroin-assisted treatment should have been introduced already. Policy only seems to radically change at the point of crisis, unfortunately, but the level of fatal overdose deaths means we're certainly there now.'

On that note, when the 2015 figures were announced he called it a national tragedy and the ultimate indicator of the country's health inequalities (*DDN*, September 2016, page 4). With the numbers up still further, does media and public opinion in Scotland accept that it is a tragedy, or is there a view that 'they've brought it on themselves?'

'There's always going to be a mixture, but my experience in doing media work around the safer injecting facility, as well as the closure of the needle exchange in Glasgow Central station, is that by and large they were very supportive. Obviously they tried to find people who were against it, but it seems there's much more consensus that this is something that's worth trying. I do get the sense that there is a shift, and that's also in terms of conversations with the wider public. In the face of so many overdose deaths it becomes harder and harder for people to argue for the status quo.'

Family focus

Alcohol Awareness Week 2017 shines a spotlight on alcohol and families, sending the message that support is always available. ***DDN*** reports

Alcohol Concern has partnered with Adfam for this year's Alcohol Awareness Week, 'Alcohol and Families', which runs from 13-19 November. The aim is to promote 'an honest discussion about alcohol', particularly when it comes to the stigma that still exists around families affected by harmful drinking.

The week kicks off with an All-Party Parliamentary Group on Alcohol Harm session on families, and Alcohol Concern has produced a set of free resources including a comprehensive guide to family support services. The pack also includes infographics and factsheets for parents, carers, children and practitioners on subjects like alcohol-related bereavement, setting up a family support group and challenging stigma. People can also order a set of 'Rethink your drink' scratch cards, which contain useful information about units and sensible drinking guidelines.

The number of dependent drinkers in England is estimated at around 595,000, and it's thought that around 220,000 children are living with an alcohol-dependent adult. As well as being twice as likely to experience difficulties at school, children of alcohol-dependent parents are also four times more likely to become dependent drinkers themselves.

'We know how few people who are alcohol-dependent actually end up engaging with services, and then obviously families are even less likely to seek help,' says Alcohol Concern's communications manager, Maddy Lawson. 'Lots of people we've spoken to anecdotally don't even know that there are services available. This week is about trying to get people talking about it, and to try to signpost them towards help.'

'What we're trying to do is raise awareness of the fact that there is family support out there – that organisations like Adfam, DrugFAM and Al-Anon are there to support people who are worried about members of their family who may be drinking too much,' adds the organisation's director of research and policy development, Dr James Nicholls. 'One of the main things we're trying to draw attention to is that people aren't alone. One of the most common feelings is that no one else is experiencing the same things, so we want to try to raise awareness that there is support out there.'

That sense of loneliness is even more acutely felt when a loved one dies an alcohol-related death, compounding the grief by adding a profound sense of shame and isolation. In circumstances like this it's vital for people to reach out, the charity urges.

'The Bereaved through Alcohol and Drugs (BEAD) partnership between Adfam and Cruse has unfortunately come to the end of its funding, but one of the things that came out of that was that people really felt it was a particularly difficult experience,' says Nicholls. 'They felt this enormous stigma, enormous sense of guilt and enormous anxiety about how people may react, while some had experienced really problematic reactions from people around them because they just didn't know how to respond. What came out of it was that it was incredibly important to seek support.'

The simple realisation that other people are going through the same thing can be hugely beneficial, he stresses. 'Collectively working with each other can be really powerful in overcoming – not the pain of bereavement, because that is what it is – but certainly some of the issues around isolation and anxiety.'

'There is support there,' he says. 'And the more people talk about these issues, the more people might feel comfortable about seeking that support.'

For more information or to download the resources, visit www.alcoholconcern.org.uk/alcohol-awareness-week

'We showed her she could manage without alcohol'

Ellie tells how tailored support transformed a mother and baby's future

WHEN KIRSTY* FIRST CAME INTO THE HACKNEY ORBIT PROJECT, WHERE WE PROVIDE SUPPORT TO PARENTS WITH YOUNG CHILDREN, she was struggling emotionally and experiencing high levels of anxiety. With a baby just a few days old, the 40-year-old mother had been referred by her local hospital, where she had been treated for depression and anxiety.

Kirsty recognised that she needed to find new coping strategies as her drinking was putting her child at risk, but she was scared that she would be unable to manage without alcohol. She had a long history of problematic alcohol use, including a period of dependency, and had suffered with depression for many years.

Initially, I worked with Kirsty in one-to-one sessions while she was on day release from hospital. In these sessions we explored triggers, her habits and beliefs about her drinking and her relationship with substances. After a couple of appointments, she agreed to us introducing her and her baby to the stay and play area where she was welcomed by the crèche team, the specialist substance misuse midwife and other service users. This helped to put her at ease and she soon felt able to engage with some of the group sessions.

Kirsty maintained abstinence from alcohol use for almost nine months and engaged well with all aspects of Orbit. When she first arrived, her baby was subject to a Child Protection Plan. However, following her positive progress, her case was de-escalated from Child Protection to Child in Need.

Having been with us for just over a year, Kirsty

'I wish we had been able to seek support'

Amy Beth describes losing her sister Carys

MY SISTER WAS A 21-YEAR-OLD UNIVERSITY GRADUATE WHEN SHE FIRST BECAME ILL. Seven years later, aged 28, Carys passed away as a result of the irreparable damage alcohol had caused to her body.

Shortly after completing her accountancy degree in 2009, Carys' long-term relationship came to an end and her life began to fall apart. As a family we started notice worrying changes in her behaviour. I returned home from university for the summer holidays and I was shocked to see the change in my sister. Within a few weeks, it was apparent that Carys was drinking daily. I frequently found bottles of vodka stashed our bedroom and in her handbag.

After much persuasion Carys agreed to attend the GP but, once there, she denied that she had a problem with alcohol and just explained that she was upset following the break-up. The GP reassured my mum that it was most likely a 'phase' and Carys was simply sent away with leaflets and advice.

For seven years we battled as a family to get Carys the help she needed to beat her addiction. Many people, including medical professionals, found it difficult to accept that Carys was an alcoholic and often assumed that we were exaggerating the extent of her addiction. Carys didn't 'look' like an alcoholic. She was a blonde-haired, blue-eyed woman in her early twenties. She had a degree, a home and a loving and supportive family – she didn't fit the bill.

The stigma that surrounds alcoholics, or indeed any addict, followed her and my family throughout her illness. While my sister was desperately ill, I didn't feel that I was able to share her illness with the people around me. I quickly learnt that if I opened up about it, people were eager to judge, which made an already difficult time harder. Even close friends failed to appreciate the severity of the situation, and I felt very alone.

I have come to accept that many people view alcoholism as a 'self-inflicted' illness. This is drastically inaccurate – and besides that, the cause of the illness itself is irrelevant when considering the impact it has on family members. We were still the family of a person with a terminal illness. We were still having to witness our daughter, sister, loved one, deteriorating in front of our eyes. The only difference for us was that we were going through that process without sympathy or support. I wish that we had been able to seek support from our friends and colleagues. That would have made a horrible situation a little easier.

decided to visit her family for Christmas. Her outpatient psychotherapy at her local hospital had just come to an end and this, combined with the season and other complicating factors, resulted in a lapse. She became distressed when she left the family to go home, and began drinking.

She was distraught and struggling to forgive herself, but her relationship with Orbit staff meant she was able to disclose this lapse and address it before it could become a full-blown relapse. A plan was agreed with the multi-agency team (MAT) and she was allocated a family support worker and linked into other community groups.

Kirsty has not drunk for almost a year now and is accessing universal childcare and starting college. Her case is now closed to children's social care, but she continues to attend one-to-one appointments at Orbit. Without our help, Kirsty would not have been able to access support as the main drug and alcohol services are adult-only services which do not cater for families.

I'm delighted to see Kirsty and her baby thrive. They have both come a long way. Kirsty's primary trigger for drinking was anxiety combined with isolation, so it's really pleasing to see her grow in confidence and engage so positively while continuing to develop a support network.

Name changed to protect identity

ALCOHOL GUIDELINES

14 UNITS per week

FOR MEN and WOMEN

To keep health risks from drinking alcohol to a low level, men and women should not regularly exceed 14 units per week and it is advisable to spread your drinking over three days or more.*

THIS IS WHAT 14 UNITS LOOKS LIKE

14 SINGLE MEASURES of SPIRIT (25ml) 40% ABV

or

6 GLASSES of WINE (175ml) 13% ABV

or

6 PINTS of ORDINARY STRENGTH BEER/LAGER/CIDER (568ml) 4% ABV

ABV = Alcohol by volume

Remember the drinks you pour at home may be **larger** than the measures used in pubs.

If you are pregnant, the safest approach is **not to drink alcohol at all,** to keep risks to your baby to a minimum.

*Department of Health, UK Chief Medical Officers' Low Risk Drinking Guidelines, August 2016

Alcohol Concern
Promoting health; improving lives

Alcohol Concern is a trading name of Alcohol Research UK, company number 7462605.

If you have any concerns about your drinking, visit **www.alcoholconcern.org.uk** or speak to your GP.

Just be yourself

'I went to church every Sunday and that's where I learned to drink with the other altar boys – after the service, any wine left was ours.'

I was born in a women's prison in 1972. I was taken away from my birth mother and fostered, then six months later my mother was released from prison and got me back – but sadly only for a short while. I was taken away by social services and the lovely couple who had fostered me decided to adopt me. Growing up, I knew none of this.

When I was around seven years old my parents told me I was adopted, and they spent hours explaining how I was loved and their real child. But that was not what I heard. All that got through to me was that my mummy didn't want me and nor did my daddy, and I couldn't understand why.

Obviously at that time I had no idea about safeguarding children and how it worked. I was in a lovely caring home and loved by my parents, yet inside I felt as if I didn't belong. It was as if a bomb had gone off in my head: why didn't my birth parents love me?

As I got to around 11 years old I started to struggle with my sexuality, although at the time I didn't quite know what I was struggling with. I went to church every Sunday and that's where I learned to drink with the other altar boys – after the service, any wine left was ours. I also heard in church that 'man shalt not lie with another man'. When I started to realise that I fancied my best friend more than I fancied my girlfriend, this was quite difficult.

Slowly I found out what and where cruising areas were – and that there were plenty of them about 20 miles away in the nearest town. It was probably not something that a 14-year-old should have known about.

I didn't really know what being gay was, I just knew I liked men more than women. This made me very frightened. I couldn't really find out information or even know who to talk to, and I felt alone and quite isolated.

My secret kind of came out at school when I was 16. I stopped doing A levels as I was being bullied daily – how was I supposed to achieve good school results when I was fending off bullies all the time?

When I was 18 I had a job that took me away from the village to a city, and I still had my secrets. On a work night out, my colleagues warned me about a street that I should not go down, as that was where all the gays went. I took note of the street name and knew I would be there the next night. It was a private members' club and they wouldn't let me in. I had developed ways of acting straight so I didn't get my head kicked in, and I couldn't even convince a gay club to let me in. Eventually I just pressed the buzzer and kissed the bouncer, who let me enter.

In the club it felt like I belonged for the first time in my life and I was at ease with who I was. I met a guy older than me, ex-army, and we got into a relationship quite quickly. It was hard being in a relationship with a guy in public, though. Once we left the safety of the club we had to be very careful – no showing affection towards each other as it was illegal to be gay if you were under 21 and not very widely accepted at any age. You could get beaten up by anyone and the police were not exactly helpful in those days.

Just after my 19th birthday I found out that he had kept a secret from me about himself. We had gone to the hospital for his appointment for cancer and the nurse suggested to me that I needed a test. A little confused I had agreed, and two weeks later I was called back. The hospital told me that I had got HIV from my partner and that I would be lucky to live another six months.

Six months to live – God really did hate me. 'I'm only 19, what do I do, who do I ask for help?,' I thought. 'My family don't even know I'm gay yet.'

Enter my coping strategy – my old friend alcohol, that had been there for me since I was 11. If I was going to die it was going be on my terms, dancing on tables, off my head on drink.

My partner blackmailed me to stay with him. He said if I left him he would tell everyone what I had got. I was very scared and very lonely. Freddie Mercury had died of Aids, so what hope was there really for the rest of us? I saw so many of my friends die of pneumonia and many just disappeared – so many people just dying in front of me.

For the next few years I watched my partner become very ill and slowly deteriorate in front of me. I was watching him die and in my head I struggled with pain and fear that this was going to happen to me quite soon. I would die a very slow, painful death.

At 25 I suffered liver failure. I woke up all yellow and was told that this was my body's way of telling me I needed to stop drinking. 'Don't be so stupid,' I replied. 'I'm dying of Aids and drinking is my way of coping.'

When I was 28, after a number of failed relationships that I realise now were all based around alcohol consumption and not love, I actually met someone who didn't drink. Maybe I would stop drinking now, I thought.

Sadly I had fallen in love with someone who was on heroin and crack cocaine and I quite quickly became addicted. My life took a whole new downward turn. The weight fell off and I really did look like an Aids victim. I was once again overwhelmed by feeling lost and lonely.

In March 2006 I overdosed on heroin and crack for the fourth time and I was taken to A&E and told I would be lucky to live for four hours. I remember the horror of people trying desperately to save my life, but thought that all the pain would be over soon – no more feeling unwanted, no more feeling that I wasn't good enough, no more being battered in relationships. Dying seemed the only way for the pain to stop. I had full blown Aids, pneumocystis pneumonia (PCP), and not much chance of living.

My parents had rushed to the hospital and entered my room in masks and gowns. I heard my father say to my mother: 'No father should ever have to bury his son.' Obviously I had overlooked the fact that they loved me as their child.

As I left the hospital some six months later, I went to detox for two months at Hafen Wen in Wales. I was allowed home for Christmas and spent time with my family – my mum and dad, my brother, his wife and their two kids, my two nephews. This time was so valuable to me.

Then it was time to go to rehab in January, at Littledale Hall in Lancaster. I spent 12 months there and made a lot of new friends. I kept the fact I was HIV positive quiet, as I wanted to be able to sort my addiction problem out rather than deal with the health condition. I really didn't think I would live long enough to complete the programme.

But complete it I did, and thought 'what do I do now?' I volunteered for a local re-use charity, Furniture Matters, then for Lancaster Advocacy. In July 2008, with the help of a few people, I set up an LGBT+ group called Out in the Bay. I wanted to support other people and let them know they had options, so that maybe they didn't make the same mistakes that I had made in life.

Today I am the CEO of the charity, we are all volunteers and I am very proud of what we do and stand for. We work with many agencies to try and support the LGBT+ community.

It can be very draining at times, as finance is limited. But we offer hope when sometimes there seems to be none, we value every single human being as an equal, and we pride ourselves on who we are, offering a safe space for people to just be themselves.

Robert Mee is chief executive of Out in the Bay, www.oitb.co.uk

Robert Mee grew up feeling that he didn't belong and used alcohol and drugs to counter his loneliness. Now, as chief executive of a thriving LGBT+ charity, he shares his story to reach out to others

POST-ITS FROM PRACTICE

WHEN ENOUGH ISN'T ENOUGH

Controlling cravings is an essential part of treatment, says **Dr Steve Brinksman**

SEAN AND I GO BACK A LONG WAY. He first started treatment 15 years ago and has had quite a few treatment episodes over the period he has been with us. These tend to follow a pattern; he starts opioid substitution with methadone, titrates up to about 60mls at which point he stops using heroin.

Then after a variable period of time – usually between four to 12 weeks – he starts to use again, occasionally at first and then more regularly, often missing pick-ups and appointments, before dropping out of treatment for a spell. Sometimes he comes back to us after a few months, sometimes more than a year goes by, and there have been interruptions while he has been in prison.

He has often done quite well in prison, away from his usual environment, and has been released on a moderate dose of methadone a number of times – but then the usual pattern kicks in. At the beginning of this year he told me he was fed up with this recurring sequence of events but not sure how we could change this.

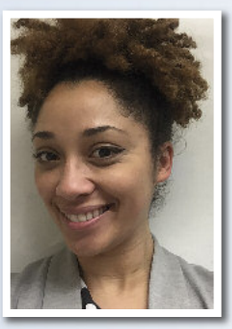
On discussing his previous treatment episodes, he told me that when he started methadone he quite quickly stopped having withdrawal symptoms, and this was the point at which his dose titration stopped. However he would still crave heroin and despite his best intentions his resolve would eventually crack and he would use again; sometimes sporadically, but always increasing until the point of falling out of treatment.

On exploring this cycle with him, he felt there was constantly a trigger, like having extra money or bumping into the wrong people. Then it occurred to me that his craving might be the main factor, so we discussed increasing his dose beyond merely stopping withdrawal. I explained this didn't mean he would never come off treatment and that long-term abstinence could still be a goal; however to get to that point he first needed a sustained spell of not using heroin.

He agreed that we should try this and we titrated him over the next few weeks to 90mls of methadone. Nine months on he remains heroin free and is as well as I have ever seen him. I expect that at some point in the future he will want to try and reduce with a view to becoming abstinent. That will be at a time of his choosing, and meanwhile he is enjoying not constantly fighting against craving.

Sean has made me wonder if we often underdose with OST, in that we treat withdrawal symptoms yet leave our patients to deal with cravings. Is simply controlling withdrawal enough? It is gratifying to see this as an area picked up in the revised Drug Misuse and Dependence: UK Guidelines on Clinical Management ('the Orange Book') and I now make a point of asking about craving as well as withdrawal symptoms, when assessing dose titrations.

Steve Brinksman is a GP in Birmingham and clinical lead of SMMGP, www.smmgp.org.uk. He is also the RCGP regional lead in substance misuse for the West Midlands.



Take time for the all-important moments of therapeutic engagement, says *Ishbel Straker*

CLINICAL EYE

And breathe…

I WAS DISCUSSING WITH A CLOSE FRIEND the other day her newly acquired qualification in counselling. We talked about the various approaches and which methods we leaned towards – I've always been a Berne groupie myself [the Eric Berne method, based on transactional analysis].

My friend asked me how I knew so much about counselling and asked if I had completed a course. I explained that as a psychiatric nurse I was trained in all of the above, with the majority of my course spent learning how to therapeutically engage with patients. I came away considering how far removed we have become as nurses from the intentions of our qualification within the addiction field, and wondered where have the majority of us have landed.

As I've mentioned before, I stumbled into the addictions field at the beginning of my nursing career and the aspect that captivated me most was having the freedom to invest my time and training in clients who were responsive. This remains the best part of working in this field for me, and one which I have made a priority for the nurses I supervise. This has been a welcome change for most, and one that has been embraced by all staff and clients. It feels important to enable nurses to use their learned skill in all areas of their working practice for their own motivation and for the quality of care provided to our clients.

Therapeutic engagement within a key work setting is like breathing for a psychiatric nurse and I have come to realise that when it is taken away, it leaves nurses bereft of their ability to have a positive impact through meaningful interactions.

That is not to say that administering medication, vaccinating clients, providing them with health checks and harm minimisation support is not essential. What I am saying is, as nurses, we should give ourselves and our clients time for a significant interaction, one which we are able to reflect upon, digest and follow up. Simply give yourself time to breath.

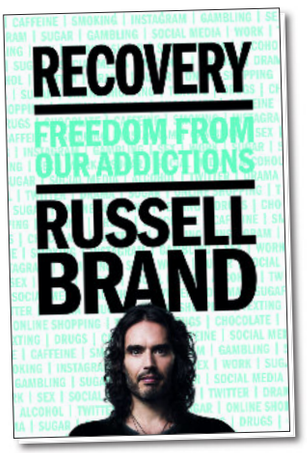
'I came away considering how far removed we have become as nurses from the intentions of our qualification.'

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.

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.

'I used to go to NA often while scripted but couldn't maintain it due to being honest about how methadone had saved my life and my complete refusal to accept the supernatural elements of the programme...'



SELF-AGGRANDISING NONSENSE

I am a little shocked and disappointed about Mr Brand's comments regarding people prescribed methadone/buprenorphine (*DDN*, October, page 11). I am 'on a script', and certainly do not think I am 'fucked' as Mr Brand so eloquently puts it.

My life is going excellently since I have been optimally prescribed methadone. I have a job/family/give back to my community and all in all am bobbing along rather well.

The problem, as I see it, is that there are MANY people doing very well on OST but as they are just busy getting on with the business of living, we are not very visible.

As a result, the only real visible OST patients are the slightly chaotic ones.

Honestly, given what he said, I'm disappointed that *DDN* gave Mr Brand such a large platform to spew his self-aggrandising, anti OST nonsense.

Sapphire Matthews, via DDN website, www.drinkanddrugsnews.com

SCRIPTED SENSE

So, Russell thinks I'm fucked due to being on a maintenance script. I must admit that in the past I did use on top until I got on an optimal dose of methadone. I've been working for over five years and many years ago I got a first-class degree while maintaining myself on OTC meds.

His views are indicative of the 12-step hardliners. Has he not read William White on medically assisted recovery? Or been in NA meetings where someone on anti-depressants has been advised to come off them as they're psychoactive?

I used to go to NA often while scripted but couldn't maintain it due to being honest about how methadone had saved my life and my complete refusal to accept the supernatural elements of the programme as I'm a dyed-in-the wool atheist and member of Humanists UK. I've heard other 12 steppers state that they wished everyone could have the programme which, to me, sounded like drinking Jim Jones' Kool Aid.

Meanwhile I'll happily stay 'fucked' according to Brand and get on with my day job helping disadvantaged people in Camden.

Peter Simonson, by email

CLARIFICATION
UKAN are here!

In our last issue (DDN, October, page 22, 'Help at hand') UKAN introduced their new online community for people working in the field of addiction. We should have included the website address in the article – you can find the UKAN community at www.ukan.network

Taking part in a recent political debate, **Andrew Horne** noticed a keen appetite for policy change

Gaining ground

AT A POLITICAL DEBATE IN INVERCLYDE, led by MP Ronnie Cowan, I shared my professional and personal views on drugs being a health and social care issue rather than a criminal one. It was heartening to hear the other panel members, all from very different backgrounds, share common ground – although for very different reasons.

At Addaction, our 50 years of working with individuals, families and communities, tells us that treatment is the thing that works. Our position is simple: people with drug misuse problems should be diverted out of the criminal justice system and into treatment – a view shared by the Scottish government, who only last week, at the SNP party conference, agreed a motion to decriminalise drugs.

During our debate, several of us discussed this topic with interested members of public. We also heard from Rod Thomson, the Royal College of Nursing's deputy president. He spoke candidly about how his views of substance misuse changed dramatically as a student nurse, when his community placement showed him the people affected.

On the flipside was panel member Anthony Gielty from The Haven, whose own drug and crime activity saw him spend 15 months of his teenage life in solitary confinement, labelled one of Scotland's most violent prisoners. After years in prison, he now provides pastoral care to men at The Haven and he's passionate about recovery and a change in Scotland's drug policy.

Neil Woods is chair of Law Enforcement Against Prohibition (LEAP) – an organisation made up of people from law enforcement, military and policy backgrounds, who campaign for evidence-based drug policy. As a former police and undercover operative, Neil's frontline career led to a personal realisation of how punitive measures do not make for cultural change, but can worsen the bigger picture.

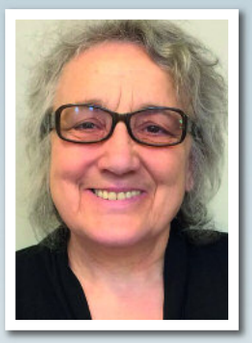
Last, but not least, we heard from Mike McCarron, one of the founders of Transform Drug Policy Foundation Scotland, who brings tangible empathy to his diverse work.

Our audience held nothing back in the debate that followed. Their honesty, insights, beliefs and determination reminded us that we are not fighting a losing battle. People from all walks of life share common ground when it comes to issues like this – and seeing this gave us all hope.

Lessons have been learned, culture is changing and there's no doubt that pressure is rising on decision-makers to change policy. At our own services within Addaction Scotland, we see every day how change is possible in the most testing of times.

Andrew Horne is Addaction's director for Scotland

Strategy for survival



Challenging times mean smaller organisations must embrace new ways of thinking, says **Caroline Cole**

We operate in difficult financial times, and for charities delivering addiction services in England the landscape is particularly challenging. As interim CEO of an exemplary residential abstinence-based 12-step treatment centre, and observing similar charities closing while private ventures open up, I have been pondering the feasibility of our charity and designing plans for our survival in this difficult world.

There are two key questions. First, can we free ourselves from the fierce statutory commissioning environment in which we work, and on which we have for a long time been dependent, while remaining true to our altruistic vision and mission? And second, can we use learning from the profit-driven corporate world to inform our strategy?

I am primarily concerned with how rehabs that are charities rather than businesses can position ourselves and borrow from corporate strategy to support sustainability. Things are not getting easier – investment in abstinence-based treatment is not on the political agenda, and the stigma of addiction prevails so public understanding and support for our services is at best limited and at worst dismissive.

Broadway Lodge in Weston-super-Mare is the oldest 12-step addiction rehab in the UK, having been operating for 43 years. Throughout this time we have supported well over 13,000 people to rebuild their lives and we have a huge cohort of alumni, some with decades of recovery. As pioneers in the 1970s and 1980s we functioned as a consultancy for other 12-step treatment centres that followed this highly successful model – people who found recovery asked us how to do it, we told them and they set up more treatment centres.

In these early days there was sufficient statutory support for people to be treated without knowing who was paying, and these people were treated alongside people who were paying privately – duke or dustman, we mucked in together. Treatment then was based on a public service and charitable ethos rather than a profit-grabbing corporate ethos.

Since then, statutory funding for treatment has gone from abundance to austerity and a place of uncertainty and peril. In the 2000s drug money was ring-fenced for many political reasons, not least the emphasis on crime reduction and public health, and although it was sensibly targeted mainly at harm reduction services there remained a small niche that offered abstinence. Clients therefore still had some choice of the treatment modalities they were offered.

The change of government in 2010 brought hope that the new PM, a strong supporter of 12-step recovery, would occasion a revival of treatment centres by insisting on a more evenly balanced provision between harm reduction and abstinence-based recovery. Sadly, this aim never percolated through to commissioners and when ring-fencing was lifted and budgets reduced throughout 2014-15 and 2105-16, 12-step and other abstinence rehabs were the main casualties.

Add to this the focus on fewer but larger contracts to drive down costs and the sector has seen integrity give way to greed and the pursuit of profits, with small/medium charities squeezed twice – at commissioning level with the cuts in overall funding, and as a potential sub-contractor to larger organisations for whom it is easier to provide the service themselves and retain the revenue. In this model, clients lose choice.

Bargaining powers are limited for charities such as ours. Because of our position in the supply chain, our suppliers (of referrals) are also our customers and this creates a dual difficulty. We as providers are both buyers and sellers but we lose any buying advantage in our need to sell. Statutory services have to be delivered in accordance with the expectations of the commissioners and all contracts or spot purchases are a trade-off between what we,

as experts, know to be effective, and what the commissioners require or allow us to provide.

So what options remain? Regarding statutory commissioning, I for one am not convinced that our long-term lobbying for change at high levels is effective. So, on the principle that if something is not working, instead of continuing to try harder let's do something different.

What we have learnt with the response to the horror of Grenfell Tower is that grass roots movements are powerful. Governments cannot control them, and they often arise where governments have failed. If we stop wasting energy doing what doesn't work, and concentrate on 'doing it for ourselves' by garnering support from the public and previous beneficiaries of our treatment, rather than the politicians, we may just be able to raise enough revenue to create a treatment and recovery system; one that actually works and is more attractive than the uninformed, misguided but dominant political narrative and broken, ineffectual system we have at present.

Harnessing alumni and family members as ambassadors and champions draws down potent support. A quick look on Facebook shows the huge cohort of fans of Broadway lodge who are eager to help and promote the rehab that gave them or their loved ones their lives back. By recognising this loyalty capital and monetising it through events and involvement, an authentic exchange of energy takes place that delivers outcomes from Broadway's commitment to, and investment in, treatment and recovery.

Negotiating collaborations with other, similar, treatment providers in order to widen the referral net and then allotting the clients fairly and accurately according to their needs is a strategy that depends on a trusting relationship that has to be built between all players in the system. This takes time and risk, but the results are profound and provide a win for all participants. Thus we develop a network of collaboration, liaising and negotiating cost savings and identifying nascent markets and those with excess capacity that we can collaboratively penetrate and secure.

Instead of remaining dependent on statutory funding and dancing to someone else's tune, Broadway Lodge – working in concert with other providers and collaborating on projects that identify synergies, share efficiencies and extend our thinking beyond the statutory realm – can deliver new and exciting strategies that foster success and enable everyone to shine.

When society improves, the people within it improve as well. Linking with like-minded providers who also trust this premise, and extending that trust to each other, provides a powerful, self-supporting system for treatment delivery that is independent of government. It involves sharing and transparency but the benefits are manifold. It is a game changer and one of the ways in which small and medium sized charities can survive and shine in this very challenging environment.

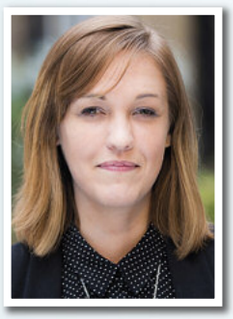
We can maintain presence and power in the treatment system, allowing us to develop a more extrovert personality and a stronger voice predicated on power harnessed through collaboration. This in turn means that clients have a wide choice and people with severe addiction be offered full abstinence-based, in-depth treatment that creates a platform for real recovery and a fulfilling life.

To return to the two questions I asked at the beginning: Can we free ourselves from the fierce statutory commissioning environment in which we presently work while remaining true to our altruistic vision and mission, and can we use learning from the profit-driven corporate world to inform our strategy going forward? The answer is a resounding YES.

Caroline Cole is interim CEO of Broadway Lodge

'We can maintain presence and power in the treatment system, allowing us to develop a more extrovert personality and a stronger voice predicated on power harnessed through collaboration.'

LEGAL LINE



‘CAN WE ASK CQC FOR MORE TIME?’

Nicole Ridgwell of Ridouts answers your legal questions

Our service is undergoing many changes after being recommissioned and we haven’t enough hours in the day. We are very short staffed and a CQC inspection is the last thing we need – we haven’t even time to complete the paperwork. Are we legally obliged to comply with the CQC’s timescale?

Nicole answers:
The short answer is yes! If you are regulated by the Care Quality Commission as a provider of regulated activities, you must comply with the reasonable requests of your regulator. The CQC in return must produce guidance to help providers to comply with the regulations. Regulation 21 of the HSCA 2008 (Regulated Activity) Regulations 2014 (as amended) says that registered persons ‘must have regard’ to this guidance.

There is a level of discretion in the regulations, in that the provider is responsible for meeting the regulations and deciding how to do this. It is not CQC’s role to tell providers what they must do to deliver their services. However, there are certain fundamental aspects of the regulations which are non-negotiable, and compliance with the request for pre-inspection information is one.

‘There is a level of discretion in the regulations.’

A provider which considers itself to have a good relationship with the local CQC inspector might consider asking for a little extra time to produce the requested paperwork, but I would urge caution. Any such request must be phrased very carefully. Inspectors are rating on the five key questions; the fifth of which is ‘well-led’, analysing the leadership and organisational culture of providers. Being able to show how you document your provider activities is key to this. Informing your inspector prior to inspection that you do not have the current capacity to demonstrate compliance is unlikely to be interpreted kindly.

While any provider (let alone the short-staffed and under resourced majority) may be tempted to consider providing pre-inspection paperwork as an unnecessary inconvenience, it may prove motivating to look at it another way. Providing evidence prior to the inspection is a key part of the inspection itself and can help to shape the physical inspection to come. A provider who appears enthusiastic and engaged will be viewed very differently by the attending inspectors than a provider who appeared truculent and unwilling.

My recommendation would be that providers aim to take the pressure off the last-minute scramble to pull information together by preparing for the inspection throughout the year. Consider the type of information CQC has requested in the past and prepare a file with that information. Include your policies and procedures (ensuring, of course, that they are up-to-date and reflective of your current practice), service user feedback, letters from families, and external assessments.

Feeding this file throughout the year will be significantly less time-consuming, less stressful, and (given that you will be including all the positive news from your service) will be an encouraging reminder of the successes over the past year.

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

MEDIA SAVVY

The news, and the skews, in the national media

Public health crises come in two forms – those resulting from naturally occurring diseases and those that are the by-product of medical care itself. The opioid crisis is the latest self-inflicted wound in public health. In the US alone, there were 240m opioid prescriptions dispensed in 2015, nearly one for every adult in the general population. In order to tackle the opioid epidemic, we must first tackle a major contributor – physician overprescribing.
***BMJ* editorial, 19 October**

I was surprised to read last week that the Czechs are not only the unhealthiest people in the EU but are the unhealthiest people in the world... It turned out that the report’s authors simply assumed that countries with high rates of alcohol consumption, smoking and obesity were sick while those with low rates of alcohol consumption, smoking and obesity were healthy... This is clearly bonkers, but it is what happens when you mistake inputs for outcomes. The ‘public health’ lobby has become obsessed with three modifiable lifestyle factors – alcohol, obesity and tobacco. Unable to see beyond this trio of risk factors for diseases of affluence and old age, there are some who have convinced themselves that they are all that matters.
Christopher Snowdon, *Spectator*, 2 October

Health messaging relies on a kind of biblical simplicity. There’s no room for nuance if it’s to hit the solar plexus. And so the call goes out: there’s no such thing as safe drinking. You’re hurting yourself – and, worse, your children! This is treacherous territory.
Anne Perkins, *Guardian*, 18 October

I wonder about parents who are up in arms at the latest findings that even moderate drinking can leave children feeling anxious, and that a tipsy parent is never a good role model... The reason this news has come as a shock is that parents these days don’t even see their drinking as a problem. It’s their right. They came of age in an era when we are supposed to have it all. No one will countenance hardship of any kind: not a moment of hunger or thirst.
Liz Jones, *Mail on Sunday*, 22 October

Officialdom is still baffled by the Las Vegas mass murders. That’s because they’re only interested in standard explanations. Almost all such killings are committed by people who have been using legal or illegal mind-altering drugs – eg ‘antidepressants’, steroids or cannabis. And we know that the killer Stephen Paddock had been taking diazepam (whose side effects include rage and violence, especially if the person is an abuser of other drugs). It really is time this connection was examined.
Peter Hitchins, *Mail on Sunday*, 15 Oct