DRINK AND DRUGS NEWS ISSN 1755-6236 DECEMBER/JANUARY 2018

DDN

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Susan Backhouse – Professor of Psychology & Behavioural Nutrition, Head of Centre for Sports Performance, Leeds Beckett University
Ian Boardley, Researcher and Lecturer (IPEDs in sport, exercise and dance), University of Birmingham
Katinka Van de Ven and **Kyle Mulrooney** – National Drug and Alcohol Research Centre, University of New South Wales
Dave Crosland – Croslands Harm Reduction Services. (Former bodybuilder and steroid user.)

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EDITOR'S LETTER

'People are missing out on engaging with healthcare'

As 2017 draws to a close we look back at a year of diminishing budgets and record drug-related deaths (page 16). While local authorities get to grips with cutting £85m from public health spending, the ACMD warned that slashing drug treatment budgets is a 'catalyst for disaster'. Throughout the year we have heard many evidence-based arguments for harm reduction initiatives. The call for supervised injection facilities is gathering momentum again, and there is continued progress on naloxone roll-out. But what about those working in harm reduction who feel they are fighting a losing battle (page 6)?

Disinvestment in harm reduction in the UK is deeply damaging. Not only are we dismissing the rights of people in desperate need of services – we are driving away those who work with passion in the most difficult environments. The result is a deskilling of this vital workforce, as we patch up services and miss out on a huge (and cost effective) opportunity to help clients engage with healthcare.

We opened a debate about commissioning in our last issue, following the ACMD's call for longer retendering cycles. On page 12 we look at the effect of this on shared care – a disturbing picture of GPs stretched to breaking point trying to make sure patients don't drop out of treatment. So it's not been an easy year, but there are clear goals to fight for. We have an amazing bank of evidence in this field – let's make sure it reaches those who need to hear it. Have a peaceful festive season and stay in touch with us as we gear up for a vigorous new year. We'll be back in print on 5 February.

Claire Brown, editor

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

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SUPREME COURT FINALLY CLEARS THE WAY FOR MINIMUM PRICING

THE UK SUPREME COURT has 'unanimously' dismissed the Scotch Whisky Association's (SWA) appeal against last year's ruling by Scottish judges in favour of minimum pricing. The decision means the Scottish Government can now finally implement the Alcohol (Minimum Pricing) (Scotland) Act 2012. 'The 2012 Act does not breach EU law,' says the Supreme Court's ruling. 'Minimum pricing is a proportionate means of achieving a legitimate aim.'

The road to minimum pricing has been a long and complicated one. The Alcohol (Minimum Pricing) Bill was passed 18 months after a previous bill had its provisions for minimum pricing removed (*DDN*, June 2012, page 4), only to face a legal challenge from the SWA and others on the grounds that the measure breached EU trade law. When this was finally rejected by the Scottish Court of Session (*DDN*, November 2016, page 4), the SWA lodged its latest appeal (DDN, December 2016, page 4).

Minimum pricing will now be introduced on 1 May 2018, with the government consulting on the proposed minimum unit price of 50p in the meantime. The ruling also makes it more likely that minimum pricing will be implemented in Wales, following the recent introduction of the Public Health (Minimum Price for Alcohol) (Wales) Bill (*DDN*, November, page 4). David Cameron's coalition government abandoned 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). However, a report earlier this year from the House of Lords Select Committee on the Licensing Act 2003 stated that if minimum pricing is introduced in Scotland and proves 'effective in cutting down excessive drinking' then England should follow suit (*DDN*, April, page 5).

'In a ruling of global significance, the UK Supreme Court has unanimously backed our pioneering and life-saving alcohol pricing policy,' said health secretary Shona Robison. 'Given the clear and proven link between consumption and harm, minimum pricing is the most effective and efficient way to tackle the cheap, high-strength alcohol that causes so much damage to so many families.' The SWA said that it accepted the ruling and that it would 'continue to work in partnership with the government and the voluntary sector to promote responsible drinking and to tackle alcohol-related harm'.

Alcohol Health Alliance chair Professor Sir Ian Gilmore said the decision represented 'a great victory for the health of the public', adding that the five years of legal challenges to the original legislation meant that 'many families have needlessly suffered the pain and heartache of losing a loved one'. The spotlight should now fall on England, where 'cheap alcohol is also causing considerable damage,' he added.

'A great victory for the health of the public.'

PROFESSOR SIR IAN GILMORE

'Now is the time for Westminster to step up and save lives,' echoed Alcohol Research UK CEO Dr Richard Piper, 'As alcohol has become more affordable, the rates of alcohol-related ill-health have risen. The fact is, something has to be done. Minimum pricing is a much more targeted measure than tax, because it raises the prices only of the very cheapest and strongest drinks on the market – those that tend to be consumed by the heaviest drinkers.'

Meanwhile, plans for a drug consumption room in Glasgow have suffered a setback following the Scottish Lord Advocate's failure to back a change of legislation to allow possession of heroin within the facility. 'This is a hugely depressing decision,' said Scottish Drugs Forum CEO David Liddell. 'It means that a drug consumption room cannot be delivered in a timescale that will respond to the pressing needs of a group who are among the most vulnerable in our society.'

UNCHARTED TERRITORY

AFGHANISTAN'S OPIUM PRODUCTION has increased by 87 per cent this year, according to the latest UNODC survey. Production now stands at a record 9,000 metric tonnes, with the area under poppy cultivation also increasing by 63 per cent since 2016. Afghanistan is the world's largest cultivator of the opium poppy, with the unprecedented levels of production and cultivation meaning more 'high quality, low cost heroin' will reach consumer markets across the world, says the agency. The increases were 'dizzying' and represented 'a profoundly alarming trend', said UNODC executive director Yury Fedotov. 'For both Afghanistan, and the world, we are heading towards uncharted territory.' *Afghanistan opium survey 2017 at www.unodc.org*

STUBBING OUT

MORE 11 TO 15-YEAR-OLDS HAVE TAKEN DRUGS THAN SMOKED CIGARETTES, according to NHS Digital's latest *Smoking, drinking and drug use among young people* report. In a survey of more than 12,000 pupils, 44 per cent had ever had an alcoholic drink, 24 per cent had taken drugs and 19 per cent had smoked cigarettes, compared to almost 50 per cent in 1996. While the 24 per cent who had ever taken drugs was up 9 per cent from 2014's figure, part of the increase may be explained by new questions on nitrous oxide and NPS, says NHS Digital, adding that 'more years of data are needed to understand if this is a genuine trend'. *Report at digital.nhs.uk*

PEOPLE'S CHOICE

MARK MOODY has been appointed as the new chief executive of change, grow, live (CGL), the charity has announced. Moody, who joined the charity 17 years ago as a frontline worker, will take over from David Biddle in 2018. The appointment also marks the first time that service users have been involved in the chief executive's recruitment and appointment process. 'I know we have appointed a person that genuinely listens and respects the views of service users,' said service user representative Sue Edwards. 'CGL is an amazing charity and this appointment will build on the real difference it makes to people's lives.' 'Working for change, grow, live is an absolute privilege and I am honoured to take up the position of chief executive, leading this fantastic organisation,' said Moody.

NEW RECRUITS

A PROPOSAL for a drug and alcohol practitioner apprenticeship level 4 qualification has been put to the Institute for Apprenticeships by the FDAP-coordinated 'trailblazer group' (*DDN*, July/August, page 18). If accepted, the group will design a standard and an assessment plan, with a consultation scheduled for next year to make sure it meets the needs of employers. The first courses would then be rolled out in 2019. *Providers who would like to be involved in the group should email fdap@smmgp.org.uk*

SIX PACK

ALCOHOL CONCERN IS PARTNERING WITH SIX CHARITIES for 2018's Dry January, the organisation has announced, including Breast Cancer Now, Action for Children, Crisis and the British Liver Trust. 'In the last ten years we have seen a 20 per cent increase in the number of deaths from liver disease, a major cause of which is drinking too much alcohol,' said British Liver Trust CEO Judi Rhys. 'Dry January should be seen as the impetus to change your relationship with alcohol forever – we recommend that you have two to three consecutive alcohol-free days every week.' *www.alcoholconcern.org.uk/dry-january*

'Impetus to change.'

JUDI RHYS

BIG RISE IN NUMBERS SEEKING TREATMENT FOR CRACK

THERE HAS BEEN A 23 PER CENT INCREASE IN THE NUMBER OF PEOPLE SEEKING TREATMENT FOR CRACK COCAINE, from 2,980 to 3,657, according to the latest figures from the National Drug Treatment Monitoring System (NDTMS). The number presenting with combined crack and opiate problems was also up by 12 per cent, to 21,854.

People presenting with a dependency on opiates made up the largest proportion of the 279,793 people in contact with drug or alcohol services in 2016-17, at 52 per cent. However this overall total marks a 3 per cent reduction from the previous year's figure, with the number seeking treatment for opiates down by 2 per cent and the number receiving treatment for alcohol alone down by 5 per cent, to 80,454. The number of alcohol-only clients in contact with services is now 12 per cent below its 2013-14 peak.

The median age of people with alcohol-only problems was 46, while opiate clients had a median age of 39. The number of under-25s commencing treatment is now 45 per cent below the level of a decade ago, with just over 11,600 18-24 year olds presenting – mainly for cannabis, alcohol or cocaine.

The number of people presenting with NPS problems was 29 per cent down on the previous year, to 1,450, largely driven by an almost 50 per cent drop in presentations among the under-25s. Individuals who present to treatment using NPS are also 'more likely to be homeless', the report states.

The exact reason for the increased prevalence of crack use was not clear but 'likely to be driven in part by the affordability and purity of crack and cocaine', said PHE's director of alcohol, drugs and tobacco, Rosanna O'Connor. Changes in 'dealing patterns and drug supply networks, such as the "county lines" phenomenon', are also likely to be playing a role, she added.

Meanwhile, figures from the Home Office show that drug seizures in England and Wales are down by 6 per cent to their lowest level since 2004. While seizures of class B drugs fell by 9 per cent, there were almost 15,000 seizures of cocaine, amounting to more than 5,500 kilograms – the largest quantity since 2003. However, 'what are portrayed as massive seizures are a minor cost of business for organised crime,' said Transform's head of campaigns Martin Powell, and 'less significant than the 2 per cent food wastage supermarkets like Morrisons factor into their supply chains'.

Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2016 to 31 March 2017, and Seizures of drugs in England and Wales, financial year ending 2017, at www.gov.uk

'What are portrayed as massive seizures are a minor cost of business for organised crime.'

MARTIN POWELL

BREAKING BARRIERS

LEGAL BARRIERS to the establishment of consumption rooms could be overcome if a pilot was allowed to operate under police supervision, says Volte Face, with the UN advising that the facilities are consistent with its conventions as long as they reduce harm and lead to treatment and rehabilitation. 'The fact that drug-related deaths are now at record levels is the clearest possible indicator that existing policies are inadequate and that new approaches and interventions are required,' said chair of the Drug, Alcohol and Justice Cross-Party Parliamentary Group, Lord Ramsbotham. *Back yard at volteface.me*

'New approaches and interventions are required.'

LORD RAMSBOTHAM

OLDER ISSUES

LAST YEAR SAW 7,327 'ALCOHOL-SPECIFIC' DEATHS IN THE UK, according to ONS figures, with the highest death rate in the 55-64 age group and fatalities among men aged 70-74 increasing by around 50 per cent since 2001. The death rate remains around 55 per cent higher among men than women, and although Scotland is still the UK country with the highest rate it has also seen the largest fall since the early 2000s. Since its last statistical release ONS has revised its definition of alcohol-specific deaths to include conditions where death is a 'direct consequence' of alcohol use – such as alcoholic liver disease or alcohol-induced pancreatitis – but not those where 'only a proportion' of deaths are caused by alcohol, such as liver cancer. The definition of alcohol-specific deaths is therefore 'a more conservative estimate on the harms related to alcohol misuse', the ONS states. *Alcohol-specific deaths in the UK: registered in 2016 at www.ons.gov.uk*

CONTROLLING CONSULTATION

THE GOVERNMENT IS CONSULTING on whether – and how – to schedule pregabalin and gabapentin under the Misuse of Drugs Act, following a recommendation by ACMD that they become class C substances. *Consultation at http://www.homeofficesurveys.homeoffice.gov.uk/s/4WE QO/ until 22 January 2018.*

ARBITRARY AGES

THREE QUARTERS OF RESIDENTIAL ALCOHOL TREATMENT FACILITIES are failing older adults because of 'arbitrary age limits', according to Alcohol Research UK. More than half exclude people at 66, while 75 per cent impose arbitrary limits of between 50 and 90, says Accessibility and suitability of residential alcohol treatment for older adults. Older people who do access rehab may also drop out because they find the environment 'unwelcoming or intimidating', the report adds. Rehab centres are 'unfairly, and perhaps illegally, excluding older people, who would otherwise benefit from residential treatment,' said CEO Dr Richard Piper. Meanwhile, a separate Drink Wise, Age Well report found that practitioners are prioritising younger people for referrals, with reasons including perceptions that older drinkers are 'too old to change', that their care needs are too complex or that their age and life expectancy mean 'it's not worth intervening'. *Reports at alcoholresearchuk.org and www.drinkwiseagewell.org.uk*

GOING COUNTRY

'COUNTY LINES' ACTIVITY – where urban drug dealing networks expand into rural areas – has now been reported by almost 90 per cent of police forces in England and Wales, according to the National Crime Agency (NCA). Almost three quarters of forces also reported associated exploitation of vulnerable people. 'The data tells us that county lines groups continue to exploit the vulnerable, including children and those with mental health or addiction problems, at all points of their drug supply routes,' said the NCA's head of drugs threat and intelligence, Lawrence Gibbons. *County lines violence, exploitation & drug supply 2017 at www.nationalcrimeagency.gov.uk*

ON A knife edge

Disinvestment in harm reduction is hurting services and failing clients, say those struggling to maintain life-saving provision. *DDN* reports

'A couple of weeks ago I had a call from the BBC, asking if I could speak on their breakfast show about issues faced by a pharmacist in Staffordshire,' says Philippe Bonnet, chair of the National Needle Exchange Forum (NNEF). 'The pharmacist said he was thinking of stopping needle and syringe programmes (NSP) because of safety reasons – his staff were being abused regularly. He mentioned a couple of incidents where a service user threatened a member of staff with a used syringe, demanding they give him needles. On another occasion someone came into the dispensary with a knife, demanding their methadone and threatening to kill.'

Bonnet pleaded with the pharmacist to reconsider, asking him 'not to punish everyone because of the actions of a couple of individuals'. He mentioned that NSPs were the reason that HIV prevalence was low in the UK, compared to Europe, and that giving out equipment is so much cheaper than the treatment for blood-borne viruses. He did not get an answer from the pharmacist when he asked him if he was going to stop dispensing methadone.

To the casual listener, the conversation on the radio may sound like discussing sensible precautions on staff protection. But for those working in harm reduction it is another red flag in a public health emergency.

The ease with which people who need these services are being dismissed is being compounded by a crisis in funding and staff morale. 'In some services, NSPs are being forgotten about,' says Bonnet.

Mark (not his real name) works in the harm reduction team of a large treatment agency, and says there has been 'a steady erosion of knowledge about harm reduction approaches since 2010'. Large cuts to funding have meant 'caseloads of increasing complexity' and evidence-based practice being replaced by 'a mush of dubious interventions', including an over-reliance on urine testing.

'Significant numbers of drug-related deaths this year, including several believed to be linked to fentanyl' have not prompted a relevant response. 'The focus appears to be more on data requirements rather than interventions around reducing risk,' he says. 'There has been no information about fentanyl circulated by the manager or the organisation, in stark contrast to the constant emails related to data needs.'

Furthermore, he sees a slide towards a deskilled workforce. Within increasingly complex caseloads, 'much of this work is done by recovery workers who are relatively new to the field but have received little or no training other than shadowing colleagues'.

Amy (who also asked for her name to be changed, because she feels she is in a 'speak out at your own risk working environment') manages a needle exchange and has worked in drug treatment services for the last five years. During this time she has seen 'the steady erosion of vital aspects of harm reduction'.

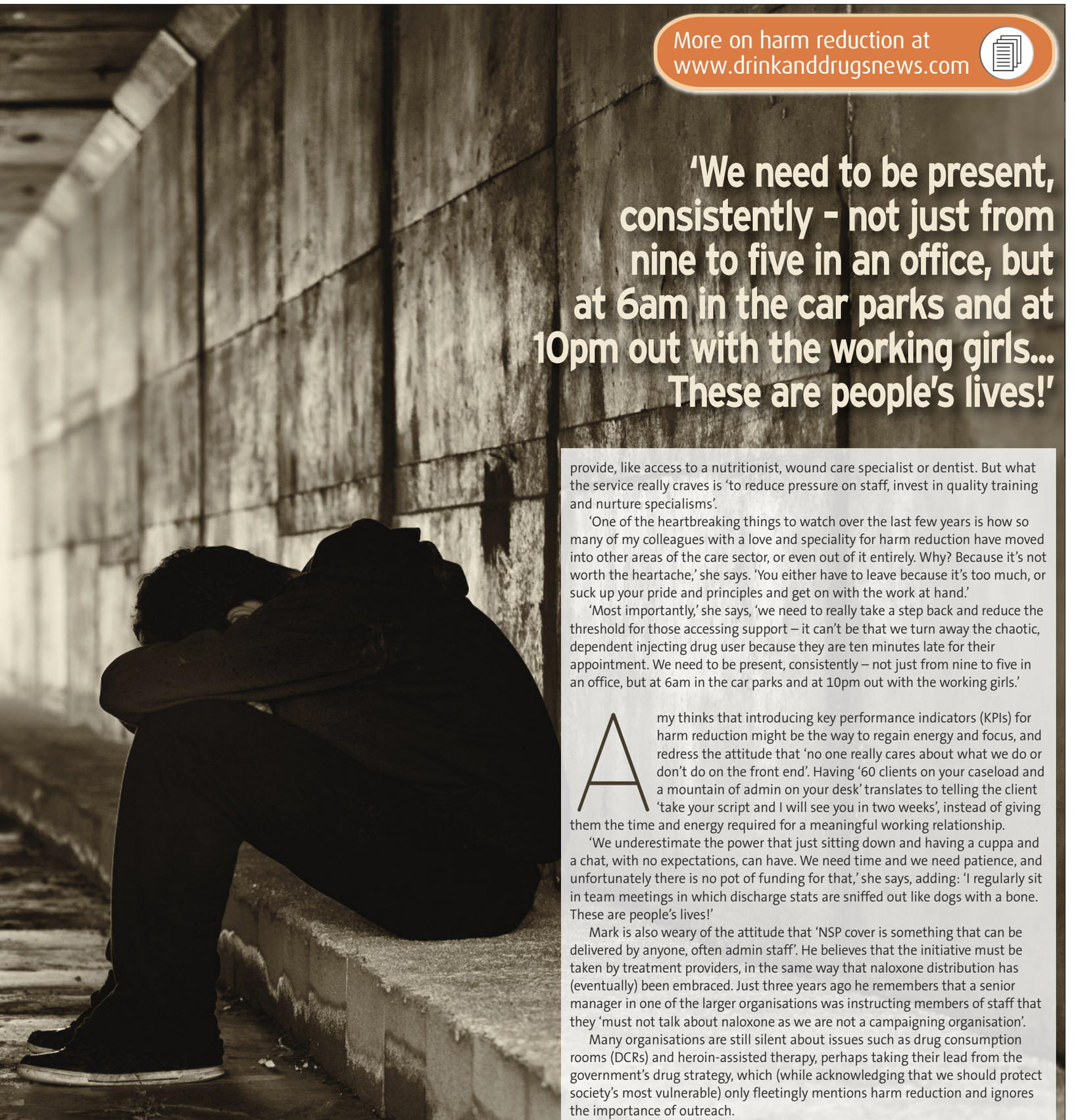
'The stuff we know works – assertive outreach, consistent and persistent support for treatment-resistant individuals – has taken a back seat in favour of assessment, TOPS [information that needs to be supplied for the Treatment Outcomes Profile] and group work,' she says. 'There is so much pressure on "positive outcomes" that ultimately very little energy is spent nailing the basics. Ultimately the pressure and expectations we have to impose on our clients is mammoth. The system feels designed for the chaotic to fail – and why wouldn't it be? Fewer chaotic clients in treatment means fewer drop-outs, fewer representations, and all of a sudden your positive outcomes and numbers are on the up.'

While Amy acknowledges some good initiatives – 'naloxone has been a game-changer, as long as you turn up to a service to pick it up' – ultimately, she says, 'we know that there are so many of our most vulnerable – in the car parks, out camping behind Tesco, sleeping in the underpass – that cannot or will not come into treatment to access such potentially life-saving interventions. What about them? We are not going to get to them, that's for certain. There's no time, no strategy, and barely enough staff to keep the hubs running. Yet again, these folks fall through the cracks.'

As well as not receiving the immediate help they need, clients are missing out on a much bigger opportunity to engage with healthcare.

'NSPs for many people represent the first, and possibly only, engagement with a "professional" agency,' says Kevin Flemen of KFx training. 'This toe-hold in a service opens up routes to so many other interventions – overdose prevention and naloxone, vaccines and BBV testing, wound care and treatment. It can be the first tentative step on a longer treatment journey.' For many it will also offer the right environment to discuss OST and life-changing options for stabilisation – steps that not only transform the individual's prospects, but also reduce the harm to their families and ultimately to society.

As a trainer he has a fair idea of the level of staff knowledge, and also of the level of priority that harm reduction is getting within services. At the moment he sees that we are devaluing it 'by failing to provide space, time, privacy and resources to make needle exchange excellent. All too often, staff with no training dole out equipment with no discussion or further engagement.' He sees that 'some areas have no trained staff or dedicated space for NSP'. As injectors turn to



More on harm reduction at www.drinkanddrugsnews.com

'We need to be present, consistently – not just from nine to five in an office, but at 6am in the car parks and at 10pm out with the working girls... These are people's lives!'

using lower-threshold pharmacy services, this is seen as a further reason to keep downgrading this essential service.

Amy's colleagues in another service from the same provider have told her about the 'no bin, no pin' policy there to encourage returns, getting rid of pre-injection swabs 'for good old soap and water – great! Unless of course you don't have access to such facilities!', and ceasing the distribution of water ampoules because of unfathomable 'concerns around legalities'.

According to Amy, a little investment in her needle exchange would go a long way. There are the material items that could be bought with more money – the BBV testing kits and homeless packs; and the specific services they could provide, like access to a nutritionist, wound care specialist or dentist. But what the service really craves is 'to reduce pressure on staff, invest in quality training and nurture specialisms'.

'One of the heartbreaking things to watch over the last few years is how so many of my colleagues with a love and speciality for harm reduction have moved into other areas of the care sector, or even out of it entirely. Why? Because it's not worth the heartache,' she says. 'You either have to leave because it's too much, or suck up your pride and principles and get on with the work at hand.'

'Most importantly,' she says, 'we need to really take a step back and reduce the threshold for those accessing support – it can't be that we turn away the chaotic, dependent injecting drug user because they are ten minutes late for their appointment. We need to be present, consistently – not just from nine to five in an office, but at 6am in the car parks and at 10pm out with the working girls.'

Amy thinks that introducing key performance indicators (KPIs) for harm reduction might be the way to regain energy and focus, and redress the attitude that 'no one really cares about what we do or don't do on the front end'. Having '60 clients on your caseload and a mountain of admin on your desk' translates to telling the client 'take your script and I will see you in two weeks', instead of giving them the time and energy required for a meaningful working relationship.

'We underestimate the power that just sitting down and having a cuppa and a chat, with no expectations, can have. We need time and we need patience, and unfortunately there is no pot of funding for that,' she says, adding: 'I regularly sit in team meetings in which discharge stats are sniffed out like dogs with a bone. These are people's lives!'

Mark is also weary of the attitude that 'NSP cover is something that can be delivered by anyone, often admin staff'. He believes that the initiative must be taken by treatment providers, in the same way that naloxone distribution has (eventually) been embraced. Just three years ago he remembers that a senior manager in one of the larger organisations was instructing members of staff that they 'must not talk about naloxone as we are not a campaigning organisation'.

Many organisations are still silent about issues such as drug consumption rooms (DCRs) and heroin-assisted therapy, perhaps taking their lead from the government's drug strategy, which (while acknowledging that we should protect society's most vulnerable) only fleetingly mentions harm reduction and ignores the importance of outreach.

'The providers of treatment really need to start to use the language of harm reduction and be clear about a commitment to those approaches, rather than continuing with a culture of harm reduction by stealth,' says Mark. 'If they don't believe that they should do everything possible to campaign for initiatives and interventions that can reduce the numbers of deaths among their service users, then we are in an impossible situation.' **DDN**

Want to comment? Email claire@cjwellings.com or add your response on the DDN website at www.drinkanddrugsnews.com

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This year's Hit Hot Topics asked, how can we give harm reduction most impact on the frontline?

DDN reports, pics by *Nigel Brunsdon*


NANNA GOTFREDSON

SUE MCCUTCHEON

THE WORD ON THE STREETS

'What the heck are we doing, criminalising people for what they do to themselves?' **Nanna Gotfredson** is the founder of Gadejuristen, the 'Street Lawyers' of Denmark. She brings legal outreach to homeless people and witnesses the 'constant war on drug users – the constant fight between doves and hawks'.

'Denmark is a welfare country – but the welfare system is designed for middle class people,' she told the HIT Hot Topics Conference. With her team, she brought harm reduction, outreach and legal aid services – 'and hugs, because we also need love' – to people on the streets. It brought her into confrontation, and then 'a critical dialogue', with the police – but it also brought progress. Denmark now has five heroin clinics and has had drug consumption rooms since 2012, all with vein scanners.

'You can get so well within a month,' she said, adding, 'We can't have a situation where people choose between HIV and a penalty.'

Sue McCutcheon is all too familiar with these issues – and the gap between poor engagement with services and the potential for radically improved health. Working as a nurse with the Homeless Primary Care Team in Birmingham, she looks for the substance users who need help but are not coming forward. Her job is about 'taking the service out to them, so they have healthcare', working for four hours a day on the street.

'Rough sleepers generally have multiple healthcare concerns,' she said, 'and many present late in the pattern of illness. Health concerns will have gone on for weeks and months, until it becomes a health emergency.' Many will have had a history of very poor engagement with services and poor care or treatment, which often colour the way they use services.

Homeless people suffered the same illnesses and challenging conditions as the rest of us, she pointed out. 'But imagine managing diabetes when you are homeless on the street, dependent on soup kitchens and without benefits.'

Within the last 18 months she had noticed skin lesions that looked like impetigo. When swabbed they turned out to be group A strep, potentially serious for those whose immune systems are poor, and PHE Birmingham confirmed there had been outbreaks. Sharing spliffs and bottles and sleeping next to someone infected made such conditions easy to spread and hard to contain, but information in drop-in centres and 'simple things like hand washing and hand gels in hostels' were effective in stopping the spread of disease.

Another simple and effective measure had been the widespread introduction of take-home naloxone, equipping people with the skills to manage resuscitation from overdose and minimise harm.

'I can't talk about homelessness without talking about NPS,' she added. 'In Birmingham, it's "mamba" – what we've seen in the last six to 12 months is shocking. One day last week we dealt with four people who were unconscious, vomit in their mouth.' Others suffered cardiac arrest in the street. 'And people say, "it's just mamba".'

Most people that McCutcheon saw and supported were groin or neck injectors – people who tended to say 'I'm alright' when they weren't. 'It's your role to make sure they're alright,' she said. 'It's about being vigilant around healthcare issues.'

The reality for many was grim, living and using out in the cold, surrounded by faeces and vomit. 'We have to look at all possible options to make a difference, including consumption rooms,' she said. 'I have a duty as a nurse to minimise harm. We need to look at every option that might produce a better outcome for people. It's about building relationships... finding ways to deliver healthcare.'


DELON HUMAN


JOSEPH KEAN


EMMA ROBERTS


PATRIIC GAYLE


NAOMI BURKE-SHYNE

Does language matter?

Different perspectives drew a very visible line between language and stigma

Speakers at Hit Hot Topics covered many areas of harm reduction, drug use and outreach, and their experience came from different countries and contexts. But there was a common theme that ran through each of their talks – the 'dehumanising language' that perpetuated stigma.

Professor Susanne MacGregor of the London School of Hygiene and Tropical Medicine charted 30 years of drug interventions. Throughout 'many contextual changes, during which harm reduction has had to struggle', language had been adapted and new terms introduced. The New Labour era, 'tough on crime and the causes of crime', gave way to 'the language of recovery'. Gaps grew between those who provided services and the people that used them.

'Let's stop using derogatory descriptions of people and move to a society where rights and evidence prevail,' said **Naomi Burke-Shyne**, Harm Reduction International's deputy director, in her talk about the oppressive impact of drug policy on science.

'We can't afford to abandon evidence, and language is a big part of that,' she said. 'We can't use stigmatising language. Let's stop talking about abuse – it implies all use is abuse.' There were words that were formerly used about the LGBT community that were 'unspeakable today', she pointed out, adding 'we need to move the same way'.

Prof Craig Reinarman of the University of California talked about drug policy reform and the 'slow motion shift' in the way we think about people who use drugs. Back in the 1980s, as initiatives spread from Liverpool like a 'crack in the stone wall of punitive prohibition', the very words harm reduction were 'blasphemy, giving the stamp of control to addiction'. Similarly, in the US, scientists 'couldn't even use harm reduction in the title of a paper' for it to be accepted.

Drug terminology became the language of fear: 'Crack cocaine is the principle cause of urban ghettos', President Reagan's drug czar William Bennett had said in the 1980s. Even now, 40 years later, discussions take place 'in a different register' for different parts of the population. White people find treatment beds waiting, not prison cells, said Reinarman.

Delon Human of Health Diplomats, Switzerland, found dialogue missing where tobacco harm reduction was concerned. Of the earth's 7bn population, 1.4bn were smokers and one out of two smokers would have a condition that would limit their life. In the UK e-cigs were resulting in the number of smokers being 'the lowest it's ever been', with the 'biggest gains in the shortest time', yet public health seemed unwilling to talk frankly about the benefits.

'We can all accept seatbelts, but for some reason they're not accepted in drugs and alcohol,' he said. 'We need to find new language to frame the debate'.

Stephen Malloy of the European Network of People Who Use Drugs (EuroNPUD) called for plain language to galvanise the pace of a harm reduction response to drugs such as fentanyl, whose dangers were well known and documented. This was an example of direct action needing to be accompanied by straight talking, he said, quoting the Canadian activists' slogan 'they talk, we die'.

For **Patriic Gayle** of the Gay Men's Health Collective, harm reduction was being compromised because the conversation between gay men and drug workers was 'conspicuous by its absence'. Back in the '80s, the LGBT community and substance misuse field came together to make sure Aids campaigning was as hard-hitting as it could be, but the dialogue had disappeared. Gay men 'need to be engaged and wooed a bit to trust services,' he said, and his organisation had had to resort to distributing resources and information that spoke honestly and openly to peers.

In a similar context, **Joseph Kean**, visiting research fellow at LJMU, looked at the language and culture of image and performance enhancing drugs (IPEDs) and asked, do we have relatable ways of reaching the 'massively underestimated' 70,000 people using these drugs?

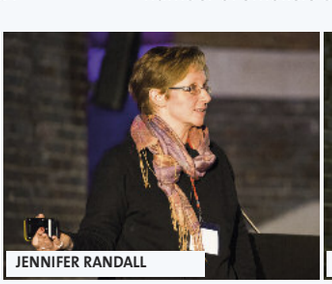
DrugWise's director **Harry Shapiro** felt that disconnection was abetted by the terminology we chose, and that drug workers must take a share of responsibility for perpetuating stigma through using 'a language of hate', which made people who use drugs feel 'expendable'.

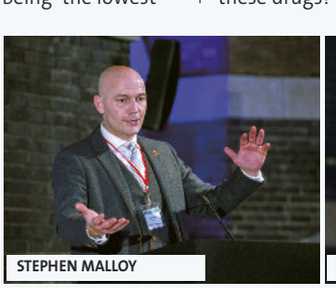
'It resides within the community and the drug sector to challenge it,' he said. 'I don't use addict, clean, drug abuse or misuse.'

Teaching a university course on personal and professional development, **Dr Jennifer Randall** had had the opportunity of exploring the triggers to attitude change. Introducing students to the *Support, Don't Punish* campaign, she witnessed how they embraced a Gabor Maté approach – 'think of people with love' and had insight into creating the right language to change culture. Using Dr Carl Hart's book, *High Price*, she encouraged 'slow critical conversations' that were effective in changing students' attitudes and preconceptions.

The final speaker, **Emma Roberts**, demonstrated the value of making grassroots user-led initiatives the mouthpiece, putting them at the forefront of commissioning and capacity building. Through describing her work with the Harm Reduction Coalition in the US, she explained that the voice of people who used drugs was vital, not just in leading advocacy, but in choosing the right language and setting the tone. Working with different drug user alliances she was able to challenge stigma and redefine recovery, demonstrating that 'it is not the opposite of harm reduction', but all part of the same necessary conversation. **DDN**


HARRY SHAPIRO

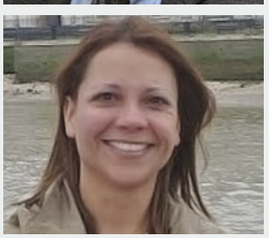

JENNIFER RANDALL

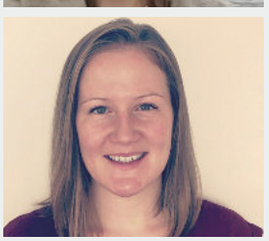

STEPHEN MALLOY


CRAIG REINARMAN

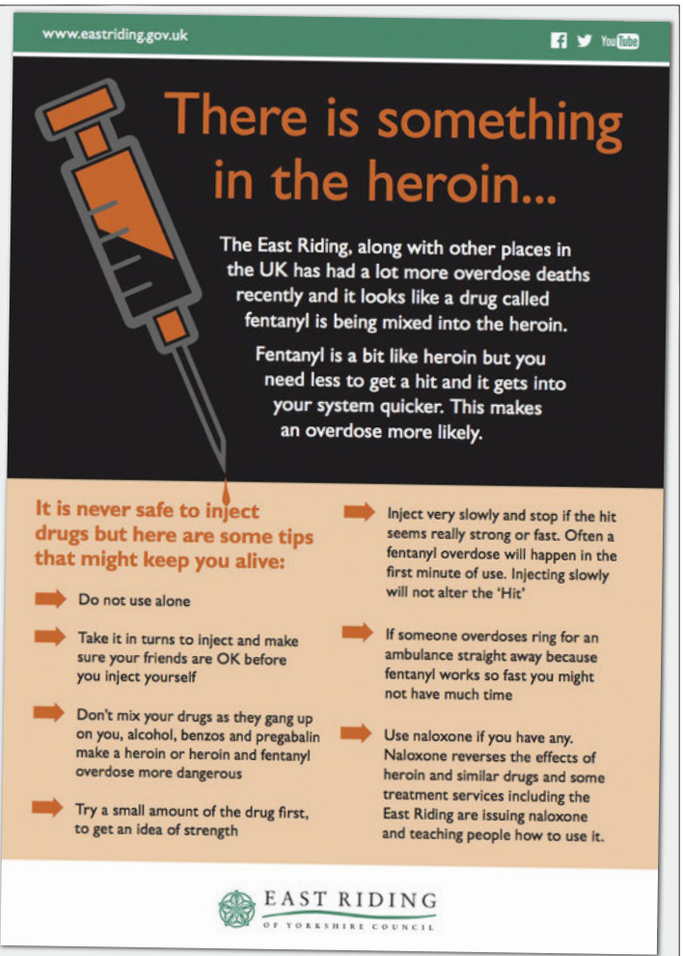

SUSANNE MACGREGOR

THERE'S SOMETHING IN THE HEROIN





Claire Gilbert, Tony Margetts, Gilda Nunez, Bryony Sedgwick and Tim Allison describe their response to the emergence of fentanyl and carfentanil in their local area



Hull and the East Riding have been at the centre of a cluster of drug-related deaths from the end of 2016 to the end of May 2017 that appear to be due to fentanyl and particularly carfentanil, one of the 40-plus analogues of fentanyl in illicit heroin. Carfentanil is so powerful it is only licensed for use in animals (eg to tranquilise elephants); an amount less than 1/2000th of a grain of salt (1 microgram) is biologically active in humans and approximately 1/1000th of a grain of salt (2 micrograms) can be lethal. This is a brief account of that event, how we responded at East Riding Public Health, and key learning points.

The first death potentially related to fentanyl/carfentanil was in September 2016 – we cannot be sure as it is not part of the standard toxicology screen routinely tested for in the UK and was not tested at the time. Numbers of deaths started to rise and remained well above typical rates until the end of May.

We sent out a request for information and a drugs worker in the local prison, HMP Hull, reported that clients believed the heroin was being cut with fentanyl or Xanax (a benzodiazepine) and witnessed people 'going over' (overdosing) as a result. In addition, pharmacists undertaking harm reduction training in East Riding reported users describing a change in how the heroin felt – that they were getting a quick strong hit. Benzodiazepines would be a concern, but were unlikely to be killing people so quickly.

Evidence from North America raised concerns over possible fentanyl/carfentanil as a cause of drug-related deaths. The first case of carfentanil was found in April, and the test was used retrospectively where possible for previous post-mortems. One pharmacist said 'they are all saying "there is something in the heroin"', and this became the title of our harm reduction leaflet which was distributed widely (see above, right). We issued a warning to local treatment services, needle exchanges and prisons, and raised awareness through the local media. Humberside Police issued a separate additional warning.

A meeting was held between the coroner, Hull and East Riding Public Health, the police, and the toxicologist, and toxicology reports were released to East Riding Public Health. Our investigations are ongoing and inquests are yet to be held on the most recent deaths.

There were 31 deaths attributed to accidental opiate overdoses between September 2016 and May 2017 in East Riding and Hull; 35 per cent had evidence of standard fentanyl and 45 per cent had carfentanil. Two cases (6 per cent) alarmingly had evidence of carfentanil but no heroin. The people most at risk were men, average age 39, long-term users, using alone. There were a disproportionate number who were homeless, living in shelters or recently discharged from policy custody. This raises the possibility that those using a new or different dealer may be most at risk.

Death appeared to happen very quickly, shown by how the deceased were found (eg still holding the needle) and biological measures (relatively low free total morphine/free morphine suggesting a rapid death). Of the 31, only four people (13 per cent) survived long enough to make it to hospital, none of whom survived due to severe brain injury, and naloxone appeared to be ineffective. It is unclear whether, if given very quickly, very high doses of naloxone may work. In one case, a user was admitted to hospital following using heroin, had taken the entirety of one kit of naloxone in the community and started a second and recovered. He died a few days later following a further hit.

Our work would suggest there are indicators that should alert an area to the possibility of fentanyl or carfentanil overdoses and lessons from our recent experience. These are:

- *Listen to current drug users from prisons, needle exchanges and elsewhere – they might spot the change in the drug supply early.*
- *Be alert to changes in the drugs market – police intelligence and treatment services reported a greater availability of heroin, at a lower price and higher strength during this cluster.*
- *Work with your partners, in our case the coroner's court, Humberside Police, treatment services, prisons, pharmacists and public health.*
- *The very high potency of carfentanil has implications for emergency services, who may need to take extra precautions to avoid contact with the substance.*
- *Watch out for features that suggest fentanyl and carfentanil and consider testing for it at post-mortem – sudden death, unusual spike in deaths, high total/free morphine ratios, lower morphine toxic levels than you might expect.*
- *Raise awareness of risks to users, eg through a leaflet (above).*
- *Consider availability of naloxone and need for higher doses.*

Dr Claire Gilbert is public health registrar, Tony Margetts is substance misuse manager, Dr Tim Allison is director of public health, Gilda Nunez is a public health officer and Dr Bryony Sedgwick is a foundation doctor in East Riding

I'm worth...

The *I'm Worth*... campaign is a disease awareness programme that has been developed and paid for by Gilead Sciences Ltd.

An estimated 160,000 people are living with hepatitis C in England. Yet, in 2015, fewer than 12,000 people were diagnosed and fewer than 10,000 people were treated.[1] Infected individuals can unknowingly transmit the infection, which makes preventing new infections – and eliminating the virus as a public health threat – a significant challenge.

SURVEY DEMONSTRATES NEED FOR IMPROVEMENT OF HEPATITIS C SERVICES

People who inject drugs are believed to represent around ninety per cent of total hepatitis C cases.[2] Over the last three months the *I'm Worth*... campaign, in collaboration with *DDN* has been surveying professionals working in substance misuse services in the UK.* The aim was to help identify and address the barriers and educational gaps around hepatitis C to ensure those working in substance misuse services and campaigns such as *I'm Worth*..., can provide meaningful support to those most at risk.

Throughout the responses, three major challenges were identified.

1. THERE IS A LACK OF UNDERSTANDING ABOUT HEPATITIS C CARE AMONGST SERVICE USERS

'I regularly see service users who are partially or substantially ignorant of issues around hepatitis C.'
Drug and alcohol support worker

Sixty-six per cent of addiction support workers state there is not enough information about hepatitis C diagnosis, care and services available for people with substance misuse problems. There is a lack of understanding of hepatitis C among service users and not enough opportunities to educate them about the disease. This demonstrates the need for additional education and resources to be made readily available for people accessing addiction support.

'We need loud voices explaining that safe treatment is now available and they [hepatitis C sufferers] are entitled to it. Clear, simple messages of getting everybody treated, and the possibility that hepatitis C could disappear from communities if everyone accessed treatment.'
General practitioner

2. SERVICE USERS OFTEN HAVE A POOR RELATIONSHIP WITH HEALTH SERVICES

'Most of our clients don't have a good relationship with the NHS and hospital care through bad experiences.'
Nurse practitioner

Almost two thirds of respondents felt that the number of hepatitis C sufferers linked to care was poor. Stigma associated with both addiction and hepatitis C means that many of these individuals are often reluctant to engage with care.

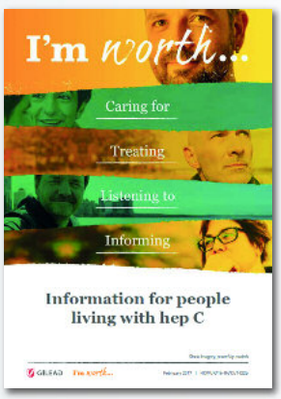
It is therefore important to tackle the stigma around the disease and develop a more systematic approach to actively seek hepatitis C sufferers and provide them with convenient ways to access treatment.

'Many clients feel that there is not enough help, support, compassion and facilities available. They suffer judgement every single day.'
Counsellor

3. CHAOTIC LIFESTYLES ARE A BARRIER TO CARE

'The biggest challenge is their general lack of self-care. Often people will be aware that they have hep C or that they are very likely to have it, but won't seek testing or treatment for years.'
Drug and alcohol support worker

Given the challenges people dealing with addiction face, managing their health is often unlikely to be a priority. Many users do not take care of themselves and are therefore unlikely to have the motivation or resources to seek diagnosis, or if they are positively diagnosed, they may be reluctant to undergo treatment. Support is needed to improve the number of people linked to care and opportunities for sufferers to share their personal experiences via peer-to-peer meetings.



The survey results show that more needs to be done to support hepatitis C patients

'[Once diagnosed] It can feel like just one more thing they have to deal with and it's not always clear to them how this may improve the quality of their lives when they are so unstable.'
Drug and alcohol support worker

The survey results show that more needs to be done to support hepatitis C patients. Despite the WHO worldwide ambition to eliminate hepatitis C by 2030, the UK is without a written disease strategy and has no complete framework in place to trace, track and treat people with hepatitis C.

In the absence of a complete care framework for hepatitis C, community-based services become a key component for HCV treatment and drug treatment centres become a gateway for people at risk to access care. It is therefore important that service workers feel confident in encouraging testing and providing service users with advice on next steps and available treatments.

The *I'm Worth*... campaign aims to help spread awareness and understanding of hepatitis C. It is designed to empower people living with the virus to get tested, access care and services, highlighting that all people living with hepatitis C deserve the chance to be treated and provided with the best care available, no matter how they were infected.

* 48 respondents which included peer support workers, GPs, social workers and nurse practitioners.

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November 2017, HCV/UK/17-04/NM/1634g

For more information and resources head to the *I'm Worth*... website: https://www.imworth.co.uk/

A RISK TOO FAR

Poor commissioning practice is putting patients' lives at stake, declared the GPs' conference

'Only recommission services if they are ineffective, dangerous or wasteful – not on a whim,' said Dr Gordon Morse, speaking at the 22nd RCGP/SMMGP conference, 'Managing drug and alcohol problems in primary care'. 'Don't recommission services that are absolutely fine.'

Throughout the day, GPs from the platform and the floor expanded on this theme with passion and anger. The existing three-year cycle of commissioning was destructive, it was agreed, and was damaging continuity of care. Delegates shared their stories of how well-functioning services had been retendered and lost to a cheaper bidder, with quality of care sacrificed in the race to slash budgets.

'There were over 3,700 drug-related deaths registered in 2016 in England and Wales – a 44 per cent increase on 2012 figures,' said conference chair Dr Stephen Willott. 'That's more than ten deaths a day and each one is a tragedy.'

The government's drug strategy has long moved away from harm reduction, OST and choices, and the 'destruction of drug services' through dramatically reduced funding and constant retendering has increased the risk level for those on the bottom rung of this 'unequal society', he said.

More than half of those who died from drug-related causes were known not to have been in contact with treatment for at least five years, so 'engaging in drug treatment clearly has a protective effect,' he said. But why were so many people not in treatment, he asked. 'Is it because of cutbacks, or are our services not accessible enough?'

The ACMD had recommended that access to allied healthcare and other services was important in promoting recovery from problematic drug use and reducing premature deaths. But local authorities often dealt with cuts by recommissioning in three-year cycles, which was 'bad for all, with dips in services and quality, damage to continuity for individuals and arbitrary changes in prescribing,' said Willott.

Throughout the day delegates were invited to share their experiences, and a picture soon emerged of (as one GP commented) 'primary care being hammered so badly that there will be no capacity to re-engage'.

Agreeing that commissioning cycles should be at least five years, the conference called for a change in practice – to 'recommission services only if the service is failing, after support to change the service has been tried'.

'The government's drug strategy has long moved away from harm reduction, OST and choices.'

DR STEPHEN WILLOTT

'I'm left trying to plug the gaps'

A local GP is stretched to breaking point

As a GP, I ran a local enhanced service for patients with a drug problem in my practice for about 14 years. Now LESs have gone, a new agency is commissioned by the council to provide treatment to my patients, and they use my service to deliver the treatment.

Continuity is key in providing an effective service, particularly to this group of patients, but the contract has been transferred every three years – so we're now on our third agency in four years. Each time the contract is put out to tender the budget is slashed.

Each agency has completely different ways of working, staff, protocols, markers of success, referral and assessment forms, and ways of communicating. We had a reliable, stable support worker with the previous agency and had just managed to set up a support group at the local youth centre. All this was lost in January of this year when the new service took over. We've had three different workers and more than six months with no worker at all, when I was left trying to plug the gap myself. My patients are thoroughly fed up with the changes and the poor reliability and continuity of the service.

The budget means staff are spread thinly, there is poor morale, retainment is low, and sickness among workers is high. Patients have come for appointments and not been told the worker is not coming. They have told their stories of past trauma and then not seen workers again – so why should they bother coming to appointments?

I can provide continuity but I don't have the time to provide all the support that is needed. It should be so much more than a script. I'm relieved to say we haven't had any drug-related deaths among our patients since our service started 14 years ago – but it is requiring so much more time and effort from me to fill in the gaps and keep the service safe.

I could not sell this type of work to other GPs with things as they are. Previously I would say how rewarding it was, and how good it was to work as part of a team. It's now stressful for all the wrong reasons, that have nothing to do with the patients.

More on commissioning at www.drinkanddrugsnews.com

‘Patients have stopped attending’

Dr Peter Exley witnessed the dismantling of responsive healthcare

I was a GP with a special interest (GPwSI) in substance misuse for around ten years, providing a clinic from my surgery to local and neighbouring practices. When substance misuse services were transferred from the NHS to local authority control in 2013, the service was put out to tender.

The existing service was based on GP patient lists, but the new service was based on local authority boundaries. As we were a mile from the county border, quite a few of our patients could no longer be treated.

We used to carry out services in a well-equipped, centrally located, modern medical centre. We provided nine hours a week of doctor time spread over two days, with flexibility to see patients outside the scheduled clinic times every day of the week. Patients could collect scripts and provide urine specimens from 8am to 6.30pm, Monday to Friday, and access urgent medical advice or discuss issues with pharmacists. Medical reviews were set as needed, from weekly to every six weeks.

The new service was set up in a church hall with no medical facilities, on the far edge of the geographical patch, and many drug users did not attend as they couldn’t afford the bus fare. Three hours of doctor time were provided one afternoon a week, and there was no easy access to medical support outside this time. Staff had their own problems to worry about – the TUPE’d drug workers were very demoralised as some had needed to reapply for their jobs three times in two years.

I have spoken to patients who have not received a medical review or given a urine screen for more than a year, and have been unable to obtain a change to their OST for over two months. I would frequently treat people’s medical problems when they attended the substance misuse clinic – mainly mental health issues, infections (especially chest), groin abscesses, DVT etc. After the change in service, patients stopped attending for medical problems and turned up in A&E.

In the ten years that we ran the service, one patient died. In the 18 months after the service ended, before I retired, three patients died – although one of these was probably not drug related. GPs preferred the old system, patients preferred the old system, drug workers preferred the old system – but the new system is cheaper.

‘Our patients are casualties of the climate’

Dr Simon Tickle has lost trust in the system

We’ve run a GP practice with additional PMS [personal medical services] funding for socially excluded patients since 2001, but without any increase since about 2005. Some of our patients have lives that might make an ‘accidental overdose’ welcome, but a treatment environment has developed which I feel has made that option more attractive.

Frankly, without increased funding, we did need the help of the new drug treatment contractors with our 150 shared-care patients, but after two years and eight changes in workers they decided they needed to crack the whip. Within three months of starting a programme to take the least stable and more complex of our patients out of shared care because they were unsuitable for it, we had two heroin overdose deaths – and we’d previously had none for years.

One was a woman with whom we had had a warm and close relationship and had supported through many ups and downs. She had learning difficulties and was on a high dose of oral methadone and ‘injecting on top’. The other was a man whom we had managed to support successfully, but on transfer he disengaged from treatment as he did not want to lose his relationship with us or be managed under their policies, and he too was soon dead.

A supportive relationship with a known care worker is a lifeline for such patients and they need to be able to opt to stay with the person or agency they trust, or at least have any transition dealt with very sensitively. I’m not attributing blame, but I would like to see more compassion and contrition. My concerned email to the local service was copied to the commissioner, but so far it has gone no further and I feel that the episode has been quietly kicked into the long grass.

These patients are casualties of a climate which puts a positive spin on what has happened in substance misuse management in recent years, but which is in fact deeply sad and bad for many. I have lost trust in the system – the same as many of my patients did very early in their lives. **DDN**

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

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

'The pressure on management to protect ideas, assets and services doesn't encourage sharing and conversation. In fact, if I was still working in the field I couldn't have even sent this letter.'

UNHEALTHY CLIMATE

Having worked in the sector for 18 years I've been part of recommissioning numerous times, even recommissioning that was delayed for three years, and I've worked 'in partnership' with primary and mental health services as well as NOMS.

It's felt to me that the service user is at risk much of the time, but good management can try to shield their workers on the ground – and therefore the service users – from much of the turmoil and politics of recommissioning. But I'm not convinced it's the right system. There absolutely needs to be review, checks and a procedure for services to progress, but we often ended up with the same provider employing us, despite recommissioning, and it wasn't credible or best for anyone. In fact it appeared to be based on friendships as much as finance.

Similarly, working in partnership is a great idea and good teams can accomplish loads together through co-location and willingness to listen, but the senior management and PR departments are always thinking strategically and competitively and I don't think that's healthy for staff or services.

The pressure on management to protect ideas, assets and services doesn't encourage sharing and conversation. In fact, if I was still working in the field I couldn't have even sent this letter.

Charlotte Richards, by email

WHAT A HYPOCRITE

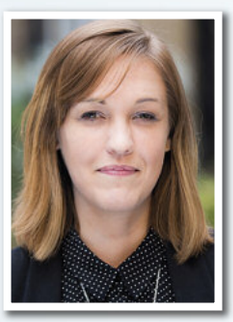
I have been on methadone maintenance more than six years. The entire time, I have not used illicit substances. I have worked full-time jobs, paid my bills, paid my taxes, and been a functional member of the community. In fact, nobody would know I'm on methadone unless I tell them. I find it quite offensive that someone would say I'm 'fucked' for being on a prescription medication (*DDN*, October, page 10).

I'm also on an antidepressant; would Russell Brand consider me not 'clean' for that as well? What about people with schizophrenia who need antipsychotics? Methadone is also an effective treatment for people with endorphine deficiency syndrome who have used opioids to self-medicate. And where is this '80-90 per cent' comment coming from? I'm fairly certain he just made that up on the spot. I know many people in MMT who do not use on top of their prescription.

Basically, he's being a self-righteous ass in order to make himself feel better, and of course, to sell books and make lots of money (which he claims is not important to him. Whatever). He seems to me to be a judgmental hypocrite of the highest order. It's people like him that are feeding into the opioid epidemic by encouraging stigma and making people too afraid and self-conscious to seek help for their disease.

Ida Swisher, via DDN website, www.drinkanddrugsnews.com

LEGAL LINE



FOREWARNED IS FOREARMED!

The CQC's new briefing is essential reading for the sector, says *Nicole Ridgwell*

On 29 November 2017, CQC published *'Substance misuse services: The quality and safety of residential detoxification'*, a briefing of the 2016/ 2017 inspection cycle. The document, which is necessary reading for all within the sector, is significant for its almost exclusively negative tone.

The nine-page document contains no reference to the hard work of frontline staff; no recognition of providers choosing to work with some of the most vulnerable in society; and no thanks for the benefits to individuals and society.

From the 68 services analysed, CQC identified a number of general concerns, including:

- *providers that did not assess risk to individual clients adequately*
- *services that did not follow best practice guidance*
- *poor management of medicines, including controlled drugs*
- *providers that did not provide staff with relevant training*
- *failure to safeguard clients by carrying out employment checks on staff*

Certain concerns raised within the document are those that you would likely find in an overview of any segment of the healthcare sector, such as record keeping errors. Other concerns are far more likely to be found in substance misuse services, for example, the reference to failing to provide treatment in line with the NICE guidelines.

NICE guidelines are guidelines not tramlines, and there are valid reasons why a service may choose to depart from them. We have been successful in challenging CQC by demonstrating why the service chose their particular course of treatment or medication. Inspectors often make judgements about substance misuse services based upon a misunderstanding of the client base.

Likewise, the issue of 'complex and varied healthcare needs' is referenced. As providers will be acutely aware, those experiencing long-term drug or alcohol dependence often suffer from a range of health issues, mental and physical – many of which reduce or disappear during detoxification. Providers know this and risk-assess the suitability of admission accordingly. Were one to believe this briefing, it would seem that providers regularly admit clients with health needs they cannot meet, indifferent to potential dangers to the individuals. Despite reading this in draft inspection reports, I have yet to find this to be true once the circumstances of the examples are explored.

Indeed, this briefing could be said to be reflective of a regulator which has entered a new sector and was not prepared for the practices they found. This is reflected in the statistics, which make for stark reading:

Of the 68 providers, 49 (72 per cent) were required to make improvements after findings that they had breached regulations of the Health and Social Care Act and failed to meet fundamental standards of care. Forty-three providers (63 per cent) were found to have breached Regulation 12 (Safe Care and Treatment) and eight providers (12 per cent) were served with enforcement action.

In summary, this is stark but necessary reading. It provides an insight into CQC's concerns, allowing providers and staff to reflect on their own practices, address any they find wanting, and ensure that they have the evidence to justify why they have chosen a particular course of treatment or medication.

It is not pleasant or encouraging reading, but it provides the sector with an insight into its regulator's view of it. Whether you agree or disagree with its findings, it is always better to know; forewarned is forearmed.

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

Addaction redoubles commitment to tackling stigma

We are determined to deal with the scourge that is stigma,' said Lord Carlile at Addaction's 50th birthday event at the House of Lords. New drugs minister Victoria Atkins, under secretary of state for crime, safeguarding and vulnerability, said that stigma was an obstacle to recovery and gave her commitment to exploring options for protecting public health funding for drug and alcohol treatment.

'I got to the point where I accepted stigma – I was a drain on society,' said Les, an Addaction volunteer from Weston-super-Mare. 'I started to believe I was a thief and a junkie – I started to accept it in the end. People focus on failures – they don't focus on people who actually make it. Addaction has given me a purpose in life. We judge people for their behaviour and we don't look underneath. To judge them compounds the shame.'

'Going into the service building was when my stigma started,' said Hayley from Wigan, who had to let her ex-partner take custody of their young daughter because of her problem drinking. 'I felt judged going in, and this made me eventually drop out of the service. But then Addaction adapted to me and I had home visits. I've been stigmatised at my daughter's school by staff and other parents, but Addaction made me a recovery champion and really helped me.'

'We want to confront stigma head-on and this means educating the public to increase empathy and understanding for those tackling drugs, alcohol and mental health issues,' said Addaction CEO Mike Dixon. 'By challenging stigma, we believe more people will come forward for support and more people will recover and reach their potential.'

Top: Minister Sajid Javid with Addaction CEO Mike Dixon, Chair of trustees Lord Carlile, Karen Tyrell and Alice Dyke.
Middle: Kate Slater of Addaction North East with Mary Glindon MP.
Right: Victoria Atkins MP

WINNERS HELP TRANSFORM LIVES IN RECOVERY

Harry Shapiro, DrugWise director (right), was among prize-winners of the Marsh Volunteer Awards, presented by Addaction and the Marsh Christian Trust. The awards recognise those who have helped transform the lives of people in recovery, and his prize for media recognised his articles, lectures and national media interviews representing the views of alcohol and drug users and challenging stigma.

'Harry is hugely knowledgeable and presents his information and evidence in a skilled non-judgemental way, acting as an advocate for service users and their family and friends,' said Jon Murray, Addaction's community engagement and implementations lead, who handed out the prizes to winners.

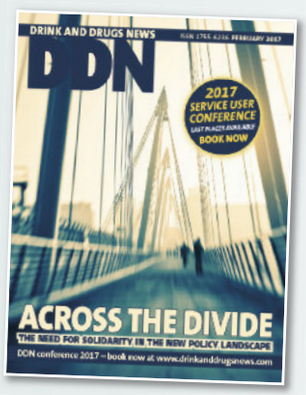
The regional award winners are Tommy Allan, Joanne Taylor, Sue Peoples, Bryony Homewood and Carole Cliffe, and recovery award winners are Lynsey McKenzie, Leanne Gillon and Harry Shapiro.

HANGING ON IN THERE

Another year of tightened purse strings and record drug deaths for a weary and beleaguered sector, compounded by the shock closure of one of its biggest names

JANUARY

The year starts on a comparatively upbeat note, with an evidence review from PHE finding that 60 per cent of England's opioid users are now in treatment – a high rate internationally – with rates of HIV infection among injecting drug users remaining at just 1 per cent. High drug-related death figures and low rates of abstinence from opiates after three and six months of treatment, however, are cause for concern, it warns. Barack Obama, meanwhile, marks the end of his presidency by commuting hundreds of 'unduly long sentences for drug crimes', in sharp contrast to the 'just say no' rhetoric soon to be espoused by his successor.

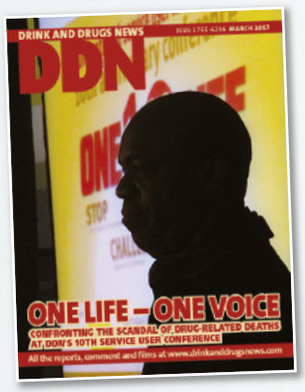


FEBRUARY

DDN's annual service user conference hits double figures with One Life, another vibrant day of debate and networking that sees delegates from across the country gather to make this tenth event the best yet. 'You have voices, you're at risk, your friends and family have died,' Collective Voice head Paul Hayes tells the conference. 'These stories need to be heard.'

MARCH

Durham Constabulary takes a bold step by announcing its intention to offer heroin-assisted treatment to problem drug users, while the Liberal Democrats call for possession of drugs for personal use to be decriminalised as a way of easing the overcrowding problem in Britain's increasingly volatile jails.

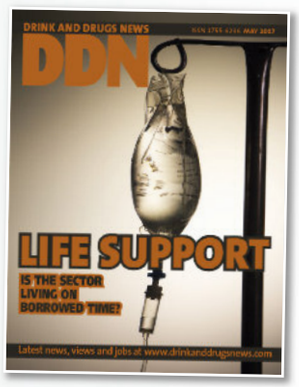


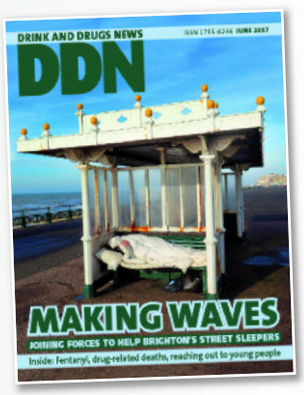
APRIL

President Trump dismays activists and harm reductionists as he signals a return to 1980s-style prevention campaigns, while closer to home the National Crime Agency issues a warning about the powerful synthetic opioid fentanyl and its analogues, which worryingly appear to be making inroads into the UK drug market.

MAY

The closure of Lifeline after almost 50 years sends shockwaves through the sector, with CGL stepping in to take over many of the contracts for its 80,000 service users. 'It's easy for the field to think that this is all the result of big bad commissioners and funding constraints,' former board member and ex-UKDPC chief Roger Howard tells *DDN*. 'But in this circumstance I think that narrative probably needs to be challenged.'





JUNE

An optimistic month for the harm reduction community as a new report moves Glasgow's proposed consumption room a step closer and one of the country's leading public health bodies calls for music festivals to provide drug testing facilities 'as standard'. Activists worldwide also take to the streets for the fifth annual *Support. Don't Punish* day of action.

JULY

The much delayed *Drug strategy 2017* finally sees the light of day, and gets a mixed reception from the field. While the government had driven a tough law enforcement approach it had to 'go hand in hand with prevention and recovery,' said home secretary Amber Rudd. The sheer scale of the challenge is aptly illustrated by analysis from the King's Fund revealing that local authorities have been forced to reduce planned public health spending on services like drug and alcohol treatment by £85m as a result of government cuts.

AUGUST

Scotland yet again records its highest ever number of drug-related deaths, at close to 900. The figure is 23 per cent higher than the previous year and more than double that of a decade ago, making the country's fatality rate the highest in the EU, while deaths in

> The National Crime Agency issues a warning about the powerful synthetic opioid fentanyl and its analogues making inroads into the UK

England and Wales are also at their highest ever. Meanwhile, Trump instructs his administration to use 'all appropriate emergency and other authorities' to respond to opioid crisis in the country, which has seen overdoses quadruple since the turn of the century. 'Not coincidentally' the level of opioid prescribing has quadrupled over the same period, points out the interim report from his own Commission on Combating Drug Addiction and the Opioid Crisis.

SEPTEMBER

Hot on the heels of last month's bleak drug death figures and the King's Fund's worrying study from July, a report from the government's own advisers, the ACMD, warns that funding cuts are now the single biggest threat to drug treatment recovery outcomes. A lack of spending on drug treatment is 'short sighted and a catalyst for disaster,' states its recovery committee chair, Annette Dale-Perera, while new figures from PHE map out the disproportionate impact problem drinking has on deprived communities.

OCTOBER

The Welsh Government introduces a bill to create a minimum unit price for alcohol, despite the Scots' attempts to do the same still languishing in legal purgatory. Release marks its 50th anniversary with a powerful pop-up exhibition, 'The Museum of Drug Policy', while Russell Brand's interview with *DDN* proves divisive.

NOVEMBER

'We constantly need to be saying, "Is our service right? Is it fit for purpose?"' Haringey's Sarah Hart says in our comprehensive look at the commissioning landscape. 'And I'm not sure that without a tender process people would do that.' To illustrate the ever-changing nature of the challenges she describes, the latest NDTMS figures show a 23 per cent increase in the number of people seeking treatment for crack, along with a 12 per cent increase in those presenting with combined crack and opiate problems. And Scotland's minimum pricing plans finally get the go-ahead after five years of legal wrangles, as the UK Supreme Court's 'landmark' ruling rejects the Scotch Whisky Association's final appeal.

DECEMBER

As another year comes to an end, plans are well underway for the 11th annual *DDN* service user involvement conference, your chance to have your say on the future of the sector. See you on 22 February in Birmingham!

All things NOVEL

Global Drug Survey 2018 – the latest version of the world's largest drug survey – has just been launched. **Prof Adam Winstock** asks for your help in assessing the new drugs on the block

Can you help us define and describe the new drugs on the block? Your experiences will help us to share information with others on what drugs are worth a mention, what's best avoided and how to stay safe.

With over 500 new drugs being identified in the last five years, we're known for having our ear to the ground and learning, before others, about drugs that come onto the market.

Our global drug survey helps us gain a unique understanding of new drugs:

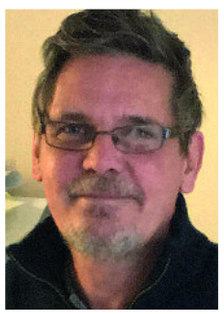
- **form (eg pill, powder, liquid)**
- **how people take it**
- **what type of other drug it most resembles (eg cannabis, trips, stimulants, opioid)**
- **how long it takes for the effects to come on**
- **how long a single dose lasts**
- **intensity of effect**
- **positive and negative effects**

Most research on drugs is based on toxicological analyses, web scrapings of user forums and emergency department presentations, whereas our research comes straight from the horse's mouth, so to speak. That's 100,000 horses in fact; all sharing their personal stories with us, in depth and in their own way – something we're really proud of. And since we started, we've produced some of the most highly cited papers on mephedrone, synthetic cannabinoids, DMT, the NBOMe series, methoxetamine and LSD analogues (and we have a new one on ayahausca coming soon).

In previous years, drugs were designed to mimic cannabis (the synthetic cannabinoid receptor agonists or SCRAs) and stimulants (cathinones like mephedrone and methylone), however, last year we found that new drugs were commonly being produced to mimic psychedelics. With the rise of fentanyl analogues and other depressant drugs, GDS aims to get a better insight into how they are being used and who is using them. That way we can share information and help support people to stay safe.

If you've tried a new drug in the last year and want to share your experiences and opinions anonymously, please take 15-30 minutes to contribute to the world's largest drug survey *www.globaldrugsurvey.com/GDS2018*

Prof Adam Winstock is founder and CEO of GDS, consultant psychiatrist and addiction medicine specialist, GDS2018 #KnowYourDrugs



Perpetrators of domestic violence are being helped to challenge and change their behaviour, as **Phil Price** explains

STOPPING THE HURT

For all the evidence linking domestic violence with drug and alcohol misuse, there's little shared knowledge of how we can best collaborate to promote safe and effective solutions. This is a shame, as our experience of working with perpetrators highlights the very real benefits for everyone involved – when the right approach is used.

The Domestic Violence Intervention Project, which takes referrals from around 30 London boroughs, worked with Cranstoun Drug Services to develop the Men and Masculinities programme to help men in recovery challenge and change the behaviour that has caused distress and damage in their relationships.

Four in every ten men attending treatment for substance use have been physically or sexually violent towards their intimate partner in the previous 12 months. Our programme works with men who use physically and sexually violent behaviours, as well emotional abuse and coercive control (we define coercive control in its broadest sense).

Working with drug and alcohol professionals, we use a special screening tool to identify these perpetrators within their cohorts. The tool is a positive mechanism to help perpetrators start taking responsibility for their actions, make sense of the worst of themselves and their experiences, and understand how they ended up in treatment and how they came to be hurting their families.

Sessions are specifically designed to address intimate partner violence and draw on a wide range of approaches including cognitive-behavioural, social learning theory, psychodrama, psychotherapeutic and relationship skills teaching. Using group discussions, perpetrators share their own stories and experiences and are then encouraged to apply insights they have gained to their own behaviours and attitudes.

We use exercises to explicitly name the substance use and its effects on the partner and children – the perpetrator's use, what they gain from this in the short and long term, how a partner may use substances as a coping strategy for the abusive man's behaviour, and how it may be used instrumentally by the man to control the woman and children further.

Four in every ten men attending treatment for substance use have been physically or sexually violent towards their intimate partner in the previous 12 months.

By the later sessions we expect perpetrators to have stopped their physical and sexual violence and stopped, or significantly reduced, their use of alcohol and/or drugs in a way that instrumentally harms, scares or controls their partner.

None of this is about anger management or counselling groups. Sessions instead create a challenging environment while offering support for personal change by addressing issues of masculinity, sexual respect, the instrumental and systematic nature of intimate partner violence, and intimacy.

They also include specific modules around the impact of domestic violence and substance use on children, considering post-violence parenting, fear and shame-based parenting, attachment, post-separation abuse, and letting go.

The programme makes survivor safety its single most important priority, as do other Respect-accredited programmes. This stamp of approval from Respect (the accreditation body for domestic violence perpetrator programmes in the UK) is very important to us and provides a mark of good practice for referrers, partner agencies and service users.

As part of this safety commitment, any man accessing treatment for his use of violence and abuse must provide contact details for the people at risk from his violence so we can provide support, safety and confidentiality for the victims of his violence.

The Men and Masculinities programme works from a drug and alcohol perspective because it deals with some of the greatest triggers for relapse by encouraging perpetrators to think through fundamental aspects of their life – relationships, conflict and contact with their children.

Working in Islington, we have now run two full programmes and, so far, worked with 30 men in total. Of the 27 men who started treatment in the Men and Masculinities group programme, 77 per cent completed at least 30 hours of intervention relating to their use of coercive control and violence.

Men on the programme recorded (via TOPS) reducing their drug and alcohol use by 29 per cent and recorded a 40 per cent improvement in their quality of life. Active, supportive contact was established with more than half of the attendees' partners/ex-partners.

At the Domestic Violence Intervention Project, we're used to saying that no single agency, sector or service can solve DV simply because it is such a complex problem – but the same is true of drug and alcohol misuse. Implementation of the forthcoming Domestic Violence and Abuse Bill and responses to Ofsted's recent call for a greater focus on perpetrators and DV prevention strategies put an onus on those working in both fields to recognise their mutual need and benefit.

More of us now need to share what we know and build new understandings to fill the current gap in service provision for integrated DV and substance misuse support, while making sure that the survivor's safety is always at the centre and is the focus of all our work.

Phil Price is development manager at the Domestic Violence Intervention Project (DVIP)

KNOWLEDGE HUB

STAY WITH IT

Tenacity is vital when it comes to working with troubled young people, Addaction's Sam Dixon tells **DDN**

When Sam Dixon from Addaction's YZUP young people's service received an 'Exceptional Individual' award at the organisation's south west regional conference in September, the case study delegates heard was of a 13-year-old girl she'd begun working with several years ago.

The young person was in 'self-destruct mode', with issues around substance misuse – alcohol and MDMA, then prescription medications – risky behaviours and self-harm, and who had been let down by a range of other agencies.

'She'd had a very late diagnosis of ADHD, which didn't help by then,' says Dixon. 'She was self-harming quite significantly – at one point we were seeing her every day, essentially making sure she was still alive. She was in supported housing for a while, which was quite challenging, and even while I was working with her other agencies would come in, get involved and then pull out.' There had also been substantial police involvement around anti-social behaviour, and 'an attitude towards her that she was a trouble maker, the leader of the pack – another bit of letting down,' says Dixon.

As those other agencies began to withdraw, what was it that made her persist? 'Gut feeling,' she states. 'My professional instinct was that there was much more going on than was clear on the outside.'

The key elements to engaging successfully with young people are a sense of humour, patience and tenacity, she stresses. 'It's about hanging on in there even when you're being told to go away, and listening to what's really happening with that person rather than just making an assumption.'

So how did she finally win her trust? 'This was a young woman who'd had a lot of professional involvement, with people saying, "She's too hard work, she keeps pushing me away, I'm going to give up." What she got from me was that that wasn't going to happen.'

Were there occasions when she did feel like giving up? 'No, there were times when it was hard, and times when I felt quite distressed myself, but I had brilliant line management support all the way. I never once thought "I can't do this anymore". All I saw in front of me was a young person in distress.'

At one point Dixon was making a weekly 120-mile round trip to see her – there was no point when management said, 'You need to give up on this and focus elsewhere?' 'No. I can't say it didn't impact on the rest of my working week, but I was very clear about why I was still involved and the work that needed to be done. I was very lucky that my manager listened to that, and the support wasn't just there – it went to a very high level at Addaction because the safeguarding concerns were so great at times. The extremity of the situation – and the fact we were seeking funding for tier 4 treatment – meant it had to be reported to our commissioner as well.'

For anyone working with similar clients, what advice would she give? 'Remember that there's a young person at the centre of it, and that they are not their behaviour. Also, be really, really clear on your boundaries. That young person always knew that it was a professional relationship, and that's what held her – she knew how far she could push me, what she could expect of me, and that it would be delivered. The building of trust was about keeping those boundaries strong, because sometimes you do just want to pick them up and take them home. In a case like this there were multiple times when I would have done that, but you don't. Being clear about her boundaries wasn't something she'd had from a lot of other professionals, so it had a really positive impact on her. And, obviously, it's about patience.'

> 'My professional instinct was that there was much more going on than was clear on the outside.'

Given how long she worked with her, at what point did she feel 'I'm starting to make some progress?' 'The nature of her mental health meant it was very up and down,' she says. 'We got her into college and things were going really well, but then they started to go wrong again. But I think once she went into residential treatment, and that had the impact it did – which was amazing – you very quickly saw definite changes in the way she thought about things, the way she felt about herself, and her developing confidence.'

Not only is this ex-client now an Addaction volunteer – 'she's very, very keen to put back into the organisation' – but she has a full-time job and is also studying for a degree. 'She blows my mind,' says Dixon. 'And it says to me, "You were right." You have to be able to see the potential in people even when they're in a place where they can't see it themselves.'

Are you involved in innovative practice? iCAAD is supporting DDN to run the Knowledge Hub – a space in the magazine to share ideas and effective ways of working. **Contact the DDN editor, claire@cjwellings.com** to be featured here.

As he prepares to leave the substance problems field, George Allan **poses a few questions and fires some parting shots**

MORE QUESTIONS THAN ANSWERS

Has the recovery movement been beneficial?

Recovery as the model for service delivery has dominated the discourse for the last decade – but has this been a good thing? There is much on the positive side: it has challenged the negative mantra that substance problems are 'a chronic relapsing condition', it has encouraged the emergence of support networks and attendant activities and it has been a driver for incorporating reintegration into mainstream services.

Aspects of the recovery agenda have, however, had a detrimental influence. An alliance of treatment ideologues – politicians for whom evidence appears to be irrelevant and celebrities determined to persuade others that what has helped them is right for everyone – has promoted an anti-treatment, abstinence-only narrative. Harm reduction has been side-lined in some areas and this has had consequences.

While it would be simplistic to blame the rise in drug deaths on recovery (the ageing cohort of vulnerable users was always going to be a challenge), the anti-OST agenda hasn't helped. Far from many being 'parked on methadone', there is clear evidence that people are often not staying on OST long enough and dropping out of services too quickly to ensure stabilisation, with the attendant increased risk of overdose.

As this becomes more evident, a rebalancing is in the offing. Scotland is looking to a 'seek, keep, treat' model to reduce drug deaths. Can we avoid the mistakes of the past by making the shift to addressing the needs of the most vulnerable without losing the gains which recovery has brought to those who feel able to move on?

Why do we pay so little attention to 'endings'?

In the light of the need to retain some people in treatment for longer, it is alarming that we give little attention to dropout and the wider processes of 'endings', both planned and unplanned. A plea to the research community – let's look more closely at endings in all their shapes and forms.

Whatever happened to controlled drinking?

Around 1980, as the dust settled on the Mark and Linda Sobell affair and the controversies surrounding research that suggested some people with significant problems with alcohol could achieve harm-free consumption, some services began to provide controlled drinking as an option. The agency I was working for was one of these. It had clear guidelines regarding suitability and a controlled drinking programme aimed to help the person to achieve non-problematic use. Few now talk about controlled drinking. There is plenty of guidance on brief interventions, whose goal is nudging risky drinkers towards moderating their consumption. But what about rigorous, individualised controlled drinking programmes? Are they still going on out there under the radar?

How can we enable people to regain a stake in society?

Reintegration means different things to different people but, for many, obtaining paid employment remains just an aspiration. There are many projects preparing people through volunteering and 'job ready' programmes, but few which open the door to actual jobs. There are shining examples, including some social enterprises, but the numbers gaining employment are small. One way to increase volume could be to engage with large scale employers who would provide training and subsequent jobs, with substance problems agencies supplying personal support over an agreed timescale. The employer bears the training costs but, in return, has the reassurance, as does the person themselves, that any difficulties will be addressed: a win for all. Piloting such a model on a significant scale is overdue.

Is stigma ever helpful?

The effects of stigma are well documented: it reinforces a negative self-image, erodes self-confidence and can serve to militate against change. But is it always counterproductive? Neil McKeganey was shouted down in the pages of *DDN* when he suggested that it wasn't. Far be it for me to defend him, but the critics missed his point. At a societal level, we define what is acceptable behaviour by stigmatising what is unacceptable. The trick, of course, is to censure certain actions (eg public drunkenness; sharing needles) while trying to avoid defining the individual solely by their behaviour – a subtle distinction nigh on impossible to maintain in the real world. Stigma is also about the use of language, of course, which takes me to my next question.

Can we please get rid of the word 'alcoholic'?

After nearly 50 years linked to the field, I still don't know what it means. It seems to suggest that there is a group of people who are somehow different in kind, as opposed to conceptualising problems as being a continuum. Worryingly, it plays into the hands of the drinks industry which has a vested interest in maintaining the fiction that there is a group of irredeemably dependent drinkers who will drink come what may, while the rest of us can imbibe with impunity. Is there a better word? How about the phrase 'person with an alcohol problem'?

Why are governments so resistant to change?

Is it just fear of tabloid headlines? Certainly some politicians are only prepared to emerge from the trenches once they retire. This resistance is not only to legislative change; there is a reluctance to back service options for which there is supporting evidence, such as heroin assisted treatment (HAT) and drug consumption rooms (DCRs). HAT has a lengthy history in the UK; from the original 'British System', through the work of Dr John Marks to the RIOTT trials, the lifesaving and stabilising virtues of HAT for carefully identified individuals is well evidenced. From Switzerland to Canada, examples of well-run DCRs demonstrate that they reduce a range of harms and can draw people into other services. Why, then, are the national and devolved governments so coy?

Should we support changes in the law?

And finally, this takes us neatly to different legislative models of control. In the current political climate, the government is unlikely to revisit the Misuse of Drugs Act anytime soon. This is a pity, as lessons from elsewhere tell us that some models of decriminalisation, linked to a health-based approach, have considerable merit.

Such developments are a long way from the more radical reforms advocated by some. It is ironic that the effective legalisation of cannabis in certain countries and states in the US comes at a time when we are beginning to understand the nature and extent of mental health problems associated with it.

While prohibition remains the cornerstone of drug control, laissez faire continues to characterise the approach taken to alcohol, particularly in England. Is this paradox sustainable?

In the minefield of social control, it is a truism that greater availability leads to more widespread use and a rise in health problems, while proscription leads to less use at a societal level but increased criminality. However, there are lessons to be learned from tobacco control. Consistency of policy across successive governments of differing political hues has led to price increases, restrictions on availability for children, the elimination of advertising and the provision of cessation services, and combined, these have achieved a remarkable public health success story. Smoking remains a drug epidemic but one which is in serious decline: a positive note to end on.

Some of the challenges the field faces are changing, many remain the same; I wish those working in services the best of luck in meeting them. And to readers grappling with their own problems I would like to say: 'if it works for you, it works for you, and don't let anyone tell you otherwise!'

MEDIA SAVVY

The news, and the skews, in the national media

Scots get set for 'booze cruises' into England as Supreme Court clears the way for minimum alcohol prices.
***Mail* headline, 16 November**

We believe minimum pricing will help in the fight against the scourge of alcohol abuse. It is not certain. It will be judged by results. But the overwhelming feeling among those taking an interest in the matter is that it must be tried... Wearying statistics tell us Scotland has long led the way on alcohol abuse. It is now, we are happy to say, leading the way on tackling it.
***Herald Scotland* editorial, 16 November**

Imposing piffling tariffs only targets the poor and looks like the paternalistic meddling of a bourgeois elite that thinks it is okay to sit at home with a bottle of chablis so long as the plebs can't get loaded on cheap cider and smash up the town centre. As if the rich can take their drink but the poor cannot.
Giles Coren, *Times*, 18 November

It is not the price of alcohol that has to change, but social attitudes to drinking. But that would be too difficult – a meaningless gesture like this is far more grandiose.
Jan Moir, *Mail*, 17 November

Cost of beer, cider and whisky to ROCKET after ruling hikes prices by 25%
***Star* headline, 15 November**

We basically tell people with this chronic illness we might be able to help you initiate your recovery, but then you are on your own. Good luck! The journey to long-term recovery for the leading cause of death for those under 50 in America shouldn't have to be all luck. It's up to all of us to get involved.
Greg Williams, *Guardian*, 4 November

The Scottish government and the supreme court have now shown that public health considerations do not have to take second place to market, competition or any other factors: they have merit in their own right. Westminster should take note.
Mary Dejevsky, *Guardian*, 16 November

It's time to shift away from a drug policy framework that's dripping with moralism while utterly lacking humanity and effectiveness. The evidence is utterly clear on this: making drug use illegal doesn't stop people doing it, and doesn't protect them from harm. Make no mistake, prohibition kills and a refusal to change direction at this juncture is unforgivable.
Caroline Lucas MP, *Independent*, 2 November

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