DRINK AND DRUGS NEWS

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DDN

THE HEART OF THE MATTER

CAN WE REPAIR A FRAGMENTED TREATMENT SYSTEM?

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EDITOR'S LETTER

'Service users must stay at the heart of commissioning'

Disinvestment and the fragmentation of services continue to dominate dialogue and debate. Yet according to Collective Voice, (page 7), we have the best opportunity in a decade to address complex problems faced by service users and their communities. The newly formed Faculty of Commissioning is on a similar wavelength (page 10) in identifying the challenges to be tackled, and they reiterate the call for better integration with mental health and housing services.

We are clear that commissioning needs an overhaul, a situation underlined by the ACMD Recovery Committee. On page 14 we look at why service user involvement must stay at the heart of this process. Tim Sampey's comments are a reminder that there are many vibrant peer-led initiatives around the country that are leant on when needed for 'service user involvement' in strategy papers, but which should be written into tender documents as a core part of services. We're looking forward to seeing many of these groups in action at our DDN Conference on 22 February.

The other important element of the consultations is to not forget the evidence that should inform them – such as when discussing a new alcohol strategy. As Dr Richard Piper reminds us (page 13), there is a large pool of evidence on which to draw in modernising the 2012 strategy. Consultations focus the mind, but we must remember to stay open to innovation. The growth of partnerships such as the alliance of NHS Trusts (page 12) offer new momentum in tackling old problems.

Claire Brown, editor

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GOVERNMENT LAUNCHES PRESCRIPTION DRUG REVIEW

PUBLIC HEALTH ENGLAND (PHE) is launching an independent review into the 'growing problem' of prescription drug dependency, the government has announced.

Dependence-forming drugs such as opioids, benzodiazepines, GABAergic medicines and 'z-drugs' like zopiclone were being prescribed to 9 per cent of the population by 2015, according to figures from NatCen, up from 6 per cent in 2000. The year-long PHE review will cover sedatives, painkillers, anti-anxiety drugs and antidepressants.

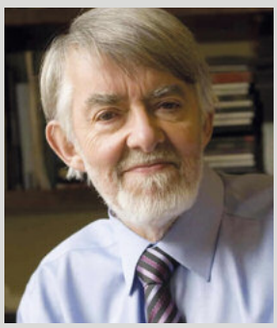
The All-Party Parliamentary Group (APPG) for Prescribed Drug Dependence has been calling for a 24-hour helpline for people experiencing dependence on these substances (*DDN*, April 2017, page 4). 'The APPG is pleased that Public Health England now agrees that prescribed drug dependence is a serious public health issue which needs to be addressed,' it said.

'Prescribed drug dependence can have devastating consequences for patients, leading to years of unnecessary suffering and disability following withdrawal from medication which has simply been taken as directed by a doctor,' said APPG chair Paul Flynn MP. 'The APPG welcomes the proposed evidence review of prescribed drug dependence and withdrawal by Public Health England as a first step towards the commissioning of services, including a national helpline, to support patients affected by this urgent public health issue.'

The Royal College of General Practitioners (RCGP), meanwhile, welcomed the review but warned that it was important not to 'automatically jump to the conclusion that more drugs being prescribed is always a bad thing', as advances in research meant a wider choice of medicines for patients.

'Many addictive medications, when prescribed and monitored correctly and in line with clinical guidelines, can be very effective in treating a wide range of health conditions,' said RCGP chair Professor Helen Stokes-Lampard.

'But all drugs will have risks and potential side effects. GPs will always prescribe in the best interests of the individual patient in front of us, taking into account the physical, psychological and social factors that might be impacting their health. However, we know most patients would rather not be on long-term medication and where appropriate we will explore non-pharmacological treatments, but these – and this is particularly so for psychological therapies – are often scarce at community level.'



...A first step to supporting patients affected by this urgent public health issue.

PAUL FLYNN MP

Meanwhile the Medicines and Healthcare Regulatory Agency (MHRA) has announced a crackdown on the diversion of prescription medicines such as benzodiazepines and other hypnotics onto the illegal market. Up to £200m worth of medicines were diverted between 2013 and 2016, the agency says, 'putting thousands of vulnerable people at risk'.

'The medicines being sold are potent and should only be taken under medical supervision,' said the MHRA's head of enforcement, Alastair Jeffrey. 'Criminals involved are exploiting people when they are at their most vulnerable; their only objective is to make money. We will continue to concentrate our efforts on identifying the criminals involved and ensure they are prosecuted through the courts.'

DYSFUNCTIONAL RELATIONSHIPS

POLICE FORCES RISK DAMAGING their relationships with local communities by being unable to demonstrate fair use of stop and search, says a report by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). While black people are over eight times more likely to be stopped and searched, drugs searches involving black people were 'less likely to result in drugs being found compared with those involving white people or other ethnic groups' says the document. 'Forces must be able to explain the reasons for any disparity in their stop and search figures if they are to enhance the trust and confidence of all communities,' said inspection lead Mike Cunningham. *PEEL: Police legitimacy 2017 at www.justiceinspectorates.gov.uk*

COPING MECHANISMS

ALMOST 60 PER CENT OF ADULTS who drink are 'doing so because it helps them to cope with the pressures of day-to-day life', according to a YouGov survey commissioned by industry-funded charity Drinkaware. 'Whilst people might think having a drink after a hard day can help them relax, in the long run it can contribute to feelings of depression and anxiety and make stress harder to deal with,' said Drinkaware chief executive Elaine Hindal. The number of people drinking 'when they are already feeling depressed or nervous, and at levels which are harmful to both their physical and mental health' was 'deeply concerning', she added. *Survey results at www.drinkaware.co.uk*

SORRY STATE

THE TREATMENT SECTOR'S ABILITY to absorb funding cuts through efficiency savings and service redesign has been 'exhausted', according to the latest *State of the sector* report, with the system 'starting to buckle under the pressure'. A high turnover of commissioners is also causing concerns about loss of expertise and there are ongoing worries about rising caseloads and erosion of service capacity, warns the document, which is published by Adfam on behalf of the Recovery Partnership. While there were 'many wonderfully talented and dedicated people' working in the sector, funding pressures meant they were 'unable to deliver to the gold-standard we'd all like to see', said Adfam chief executive Vivienne Evans. *State of the sector 2017 – beyond the tipping point at www.adfam.org.uk*

POOR PROVISION

LEVELS OF NALOXONE PROVISION by local authorities are 'chronically inadequate' and 'certainly not sufficient to prevent opioid deaths to any meaningful extent', according to research by Release. Although take-home naloxone is now provided by 90 per cent of local authorities (*DDN*, September 2017, page 4), FoI requests revealed that just 12 take-home kits were being given out for every 100 people using opiates. Naloxone coverage was found to be between 1 and 20 per cent in more than 70 local authority areas, while even the best-performing council, Somerset, still achieved less than 50 per cent coverage. *Survey results at www.release.org.uk/naloxone*

CHANGING MARKETS

THE TOTAL AREA OF OPIUM POPPY CULTIVATION in Myanmar has fallen by 25 per cent from 2015 levels according to UNODC. The drop is in sharp contrast to Afghanistan's 87 per cent increase in opium production last year, which has taken the world into 'uncharted territory' according to UNODC executive director Yury Fedotov (*DDN*, December/January, page 4). Myanmar's declining cultivation is likely to be the result of a changing regional drug market in East and Southeast Asia, says the agency, with its shift towards synthetic drugs like methamphetamine. *Myanmar opium survey 2017 at www.unodc.org*

We are in 'uncharted territory'

YURY FEDOTOV

INTRODUCE CIGARETTE-STYLE LABELLING FOR ALCOHOL, SAYS PUBLIC HEALTH BODY

IT SHOULD BE 'MANDATORY' to include the government's low-risk drinking guidelines of 14 units per week on alcohol labels, says the Royal Society for Public Health (RSPH), alongside calorie-content information and warnings about drink driving. Labels could also potentially feature 'explicit cigarette-style warnings of the link with health conditions such as bowel and breast cancer' as well 'traffic light' colour coding, the organisation states.

The recommendations form part of a new report, *Labelling the point*, published in response to a perceived 'alcohol health awareness vacuum'. Only ten per cent of people are aware of the links between alcohol and cancer, says RSPH, while just 16 per cent are aware of the government's unit guidelines and only 20 per cent are able to correctly estimate the number of calories in a glass of wine. Including information on calorie content per serving could result in a ten per cent swing in 'consumer purchasing decisions from the highest alcohol drinks to the lowest', across all main drink categories and socio-economic groups, the document claims.

The report is partly based on a survey of around 1,800 people originally commissioned in partnership with industry body the Portman Group. However, the Portman Group has since 'moved to make alcohol labels even less informative to the public than they are at present', says RSPH, by releasing updated guidelines to manufacturers that no longer include the government's low-risk drinking limits. Unit information alone is 'largely useless' to most consumers unless shown in the context of the recommended weekly limits, stresses RSPH. The Portman Group's updated guidance indicates that the body is 'no longer serious about setting a challenge for industry to play their part in informing the public and protecting their health', the royal society adds.

'Having a drink with friends or family is something many of us enjoy. However, the potential health consequences of alcohol consumption are more serious than many people realise,' said RSPH chief executive Shirley Cramer.

'If and when people choose to drink, they have the right to do so with full knowledge of both what their drink contains and the effects it could have. Consumer health information and warnings are now mandatory and readily available on most products from tobacco to food and soft drinks, but alcohol continues to lag behind. If we are to raise awareness and reduce alcohol harm, this must change.'

> There is little public interest in a radical overhaul of drinks labelling.
> JOHN TIMOTHY

The Portman Group's decision to 'weaken' their labelling recommendations showed that 'alcohol producers wish to withhold information on alcohol and health from the public', added Alcohol Health Alliance chair Professor Sir Ian Gilmore.

However, Portman Group chief executive John Timothy responded by saying that the original research co-funded with RSPH 'found little public interest in a radical overhaul of drinks labelling, and strong opposition to cramming more information' onto packaging. It showed that 86 per cent of consumers 'only look at labels for factual information and branding' and 80 per cent wanted to see 'less cluttered' labels. 'When asked specifically about health, 70 per cent said the current approach was about right,' he stated.

'These findings support the approach taken by the industry in developing updated voluntary guidance which includes a whole section on how producers can display the CMO's guidelines on labels,' he continued. 'To suggest otherwise is misrepresentative. The Portman Group remains committed to providing consumers with accurate and accessible health information.'

Report at www.rsph.org.uk

CEASING CESSATION

JUST 61 PER CENT OF LOCAL AUTHORITIES now offer smokers access to 'evidence-based support', according to a report from Cancer Research UK and ASH. Cuts to the public health budget have meant 'dramatic changes' to smoking cessation services, says the document, with at least one English council now having a 'zero budget' to address smoking. 'Shrinking public health budgets make it tougher to provide smokers with quit services while tobacco companies pocket a billion in profit every year in the UK,' said ASH chief executive Deborah Arnott.' The government should place a levy on the industry to fund the support smokers need.' *Feeling the heat: the decline of stop smoking services in England, at www.cancerresearchuk.org.*

> 'The government should place a levy on the industry'
> DEBORAH ARNOTT

SCOT CALL

THE SCOTTISH GOVERNMENT should produce a hepatitis C prevention strategy with targets to 'decrease national incidence, mortality and overall prevalence', says a report from the Hepatitis C Trust. The document also urges the government to establish opt-out testing in substance misuse services and issue guidance on its effective implementation in prisons. 'Without renewed efforts to find and treat the thousands of undiagnosed patients living with hepatitis C, Scotland may no longer be considered a world leader in tackling this deadly virus,' said trust chief executive Charles Gore. Meanwhile, England could be on course to be the first country in the world to eliminate hep C, according to the NHS, with the health service and drug companies working together to identify more people who need treatment. *Eliminating hepatitis C in Scotland: a call to action at www.hepctrust.org.uk*

PRICED OUT

MORE THAN 100 MPS, police commissioners, charities and health organisations have called for minimum pricing to be implemented in England 'immediately'. 'Lives will be lost if Westminster delays further on the issue', said an open letter to the *Sunday Times* signed by representatives of the royal colleges of physicians, psychiatrists, nursing, GPs and anaesthetists, as well as the BMA, Cancer Research UK, the Children's Society and others. Minimum pricing will be introduced in Scotland in May, following a five-year delay as a result of legal challenges from the drinks industry (*DDN*, December/January, page 4). A similar delay in England would lead to more than 1,000 deaths and 182,000 alcohol-related crimes, the letter claims, as well as a cost to the NHS of £326m.

LANGUAGE MATTERS

NEGATIVE PORTRAYALS IN THE MEDIA and politics are reinforcing the perception that drug use is 'immoral' and people who use drugs are a threat to society, says a report from the Global Commission on Drug Policy. This in turn increases stigma and discrimination and means that people who use drugs are seen as 'sub-human, non-citizens, scapegoats for wider societal problems' and undeserving of the right to health, says *The world drug perception problem: countering prejudices about people who use drugs*. Policy makers should aim to change perceptions of drugs and people who use them by providing reliable and consistent information, the report urges, while 'opinion leaders' in the media should promote the use of non-stigmatising language. *Report at www.globalcommissionondrugs.org*

THE HEART OF THE MATTER

Can we meet six basic challenges to repair a fragmented treatment system, asks **Paul Hayes**

Brexit continues to dominate mainstream debate. But far more important to most people, particularly the poor, the marginalised, and the 'left behind' is the cumulative impact of years of austerity and the continuing failure of the economy to grow.

The prime minister's promise to overcome the 'burning injustices' which blight so many lives, seems distant. The reality of sluggish growth, falling wages, and slow but steady degradation of the services on which the poor and vulnerable rely, provide the context in which drug and alcohol treatment providers work and our service users live.

Below are six of the key challenges facing the drug and alcohol treatment system during 2018. As the government recognised in last year's drug strategy, truly effective interventions depend on their cumulative impact. People need adequate access to physical and mental health treatment, a realistic prospect of a job, a safe place to live, and enough income for food and clothing.

Since the financial crash of 2008, the cumulative impact of squeezed budgets and changes in policy have placed strains on service users' capacity to survive and recover, which treatment providers cannot address in isolation – no matter how brilliantly they implement the drug strategy or how assiduously they abide by the clinical guidelines.

******* ALCOHOL *******

Only one person in six who needs alcohol treatment is able to access it. Alcohol harm is concentrated in our poorest communities, with 30 per cent of all alcohol consumed by 4 per cent of the population. The health damage, the societal consequences and the costs to the NHS are well understood. Despite this, the government has thus far resisted publishing an alcohol strategy identifying how it will reduce the overall harm of alcohol use and in particular how it will close the gap between the growing need for treatment and shrinking capacity. There is growing political pressure for the government to be more active in social policy, and an alcohol strategy would be the ideal place to begin.

******* DRUG-RELATED DEATHS *******

The Local Government Association, PHE, and the ACMD have all identified treatment for England's heroin-using population as the key to reducing drug-related deaths. Being 'in treatment' is a protective factor: deaths are significantly lower within the 60 per cent in contact with services than the 40 per cent who are not. Every local authority commissioner and provider should be striving to understand why people do not access services and find the most effective way to reach them. However, with providers extended to the limit to meet the needs of the 60 per cent, resourcing will be fundamental to success.

******* DISINVESTMENT *******

In 2012/13, total spend on drug and alcohol treatment in the community and prison was more than £1bn. It is now around £750m. Local authorities are increasingly focusing their commissioning on 'must haves'; protecting rapid access to prescribing services by limiting the availability of the wider services that are crucial to success – those relating to homelessness, mental health, employment, offending, and services specific to gender, culture and communities. As services become hollowed out, the spectre looms of a government committed to recovery presiding over a system which is forced by financial constraints to focus almost exclusively on maintenance prescribing.

******* FRAGMENTATION *******

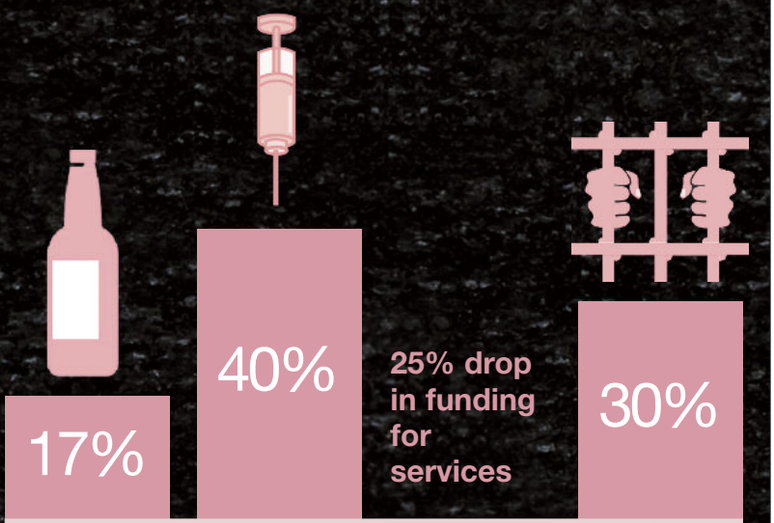
The 2013 reforms brought drug and alcohol treatment together as the responsibility of local authorities – but elsewhere we have seen fragmentation of provision rather than its integration. Most significantly, as the cohort of heroin users from the late 20th century epidemic age, their need for mainstream health services has grown dramatically. Decades of heroin use, accompanied by smoking, poor diet, insecure accommodation, fragile mental health, and alcohol misuse, has created a population with severely compromised heart, lung and liver function, whose health needs are more akin to those of the elderly than the

More on services at www.drinkanddrugsnews.com

middle aged. A hard-pressed NHS struggles to respond to those it experiences as 'challenging', and service users are easily discouraged by the bewildering range of NHS signposts and pathways.

Health and wellbeing boards, created to knit local authority and NHS services together, are preoccupied with the massive challenge of integrating health and social care and pay scant attention to lower priority issues such as alcohol and drug treatment. The impact of this is that a vulnerable population is excluded from healthcare, resulting in unnecessarily early deaths – in far greater numbers than the overdose deaths reported in the drug-related death figures.

A similar chasm has been allowed to develop between prison and community services. Since 2013 prison drug and alcohol treatment has been commissioned by NHS England and usually delivered within large multi-site contracts with generic healthcare providers. Startlingly this means that neither the Ministry of Justice nor NHS England know how much is spent on drug and alcohol treatment in custody – however the MOJ's best estimate suggests that prison treatment has also experienced a 25 per cent reduction since they assumed responsibility. Before this, prison and community treatment was commissioned as one system to facilitate effective transfer between the two settings. The failure of the current system is illustrated by the fact that only 30 per cent of those assessed as having a continuing need for treatment on release actually establish contact with a community service.



******* COMPLEXITY *******

The narrowing of local authorities' ambitions for their specialist treatment systems is accompanied by continuing decline in the generic services that are fundamental to recovery. Despite the government's laudable commitment to parity of esteem for mental health within the NHS, the secretary of state has acknowledged that the need to recruit and train enough doctors and nurses will delay the achievement of this aspiration for many years.

The abject failure of the government's Transforming Rehabilitation reforms of the probation service dramatically curtailed the support available to offenders serving community sentences, and on licence following imprisonment. In addition, the probation service is now largely absent from local strategic planning processes in which they used to play a prominent role. While these failings are largely hidden, what is visible in cities across the country is the dramatic increase in street homelessness, which has doubled since 2010 and increased 16 per cent over the past year. This is only one facet of unmet housing need for people with drug and alcohol problems, but it is currently the most visible manifestation of the failure of society to meet the needs of its most vulnerable citizens.

******* CRIME *******

The government's modern crime prevention strategy, launched by then home secretary Theresa May in 2016, identifies drug treatment as one of society's most effective tools to reduce crime. Home Office analysis attributes half the rise in acquisitive crime at the end of the 20th century to the impact of the heroin epidemic, and a third of the reduction this century to the improving availability of treatment from 2001 onwards.

The clear connection between heroin/crack dependence and crime made the police strong advocates of improved treatment access, and they were extremely influential players in drug treatment policy between 2001 and 2010. Over the past decade police interest in drug-related offending and their advocacy of treatment diminished as acquisitive crime continued to fall and priorities shifted to sexual offences, violence against women and girls, cybercrime, and terrorism.

Very recently there has been some reawakening of police interest in drug treatment. Traditional crime is beginning to increase; burglary is up by 8 per cent; theft from vehicles is up by 15 per cent; drug-related gang activity is becoming more of a concern and appears to be linked to increasing use of firearms. Use of firearms declined significantly alongside other drug-related offences from 2005 onwards but the most recent crime figures show an increase, including a 20 per cent increase in the use of handguns. None of these increases can be exclusively linked to the drug market, but if ready access to a well-funded drug treatment system helped crime fall between 2000 and 2010 we should not be surprised to see a reversal of the trend.

Despite the scale of these overlapping challenges there are reasons to be optimistic that we can find effective ways to respond. The drug strategy is a huge step forward in endorsing evidence-based practice and explicitly recognising the breadth of the responses needed to succeed. The routine denial of issues such as disinvestment and fragmentation that characterised official responses before the publication of the strategy has been replaced with greater willingness to own the scale of the challenge and seek pragmatic solutions. The increase in traditional crime creates a rationale for police to renew their advocacy of treatment, which has significant potential to shape local investment decisions.

Most importantly, the home secretary now chairs a cross-government board to drive this agenda forward. Her leadership, supported by the objective grassroots view of a newly appointed recovery champion, and underpinned by the willingness to hold local authorities to account (via PHE) for their delivery of key metrics, provides the best opportunity in a decade to address the complexity and scope of the problems facing service users and their communities.

Paul Hayes is head of Collective Voice

OPINION

Shocked by cases in his constituency, **Bambos Charalambous** MP is calling for government action on Xanax

ANXIOUS TIMES

The powerful sedative Xanax is being used by young people across the country (*DDN* April, page 6). Some are taking it to self-medicate to cope with anxiety, while younger teenagers are being groomed and exploited by drug dealers taking advantage of the drug's 'zombie-like' effects.

On 15 January, Xanax was mentioned for the first time in the House of Commons chamber. I held the debate to bring to light a disturbing case of a 14-year-old girl in my constituency who had become hooked on the drug. Her mother had contacted me shortly after I was elected to ask for my help and this was the first time I had heard of Xanax. I then became aware of how widespread its use is.

For the next six months, I pretty much asked every young person that I met if they had heard of Xanax. They almost laughed in my face at my ignorance and I've since been instructed to use the word 'Xanny'. I've now listened to more rap music than I ever thought I would and was utterly shocked by the selfie Youtube video shot just six hours before the death of Lil Peep from a Xanax overdose.

Some young people in their early twenties told me that they easily buy Xanax online for as little as £1 a pill and use it to self-medicate for their anxiety. This is worrying enough, but the case of my 14-year-old constituent is far more sinister. Zoe (not her real name) was a bright and popular girl with lots of friends, but after she was approached by an older girl at her school and an ex-pupil, she started going to private raves and parties in houses across North London. She was swept up in a whirl of excitement by this new lifestyle and was introduced to Xanax, mixing it with alcohol and becoming sedated.

Zoe would go missing for whole weekends and would come home with marks and bruises on her arms and legs with no recollection of how she got them. The vulnerable state that Xanax puts users in leaves them extremely vulnerable to abuse, and who knows what happened to Zoe – she certainly can't remember. On some occasions, Zoe became aggressive towards her mother and after a fraught evening she ended up spending the night in a police cell. Again, she had no recollection of any of this.

Despite help from the police and abduction warning notices that were served on six people, Zoe was now being heavily groomed. 'Baggies' were hidden in Zoe's bedroom and things took a turn for the worse when Zoe and her best friend were found in a mess on the school premises after taking Xanax. Zoe wasn't excluded and was allowed to stay on at school with some extra support services. Zoe's mother, and the school tried their best but she was still able to get hold of dirt-cheap Xanax, peddled by a dealer from a booth in a McDonalds restaurant right next to a police station. All the information that had been pieced together was passed on to the police who arrested three people on drug-related charges in December. This was not before Zoe and her best friend were found to be drunk on the school premises and then permanently excluded from school.

> 'Some young people in their early twenties told me that they easily buy Xanax online for as little as £1 a pill and use it to self-medicate for their anxiety.'

Whether the glamourisation of Xanax use is a matter of art imitating life or life imitating art, the problem is certainly a real one in the UK. The truth is that there is a cultural and age divide and, for whatever reason, the fact remains that Xanax is the drug of choice for some young people. Maybe it's because it helps numb the pain, maybe it's because it is fashionable, maybe it's because it is cheap and easy to get hold of – I can only speculate. I've called on the government to research the prevalence of Xanax use in the UK, to raise public awareness about the effects and potential harms and to provide specialist support for those who have developed a dependency.

Bambos Charalambous is MP for Enfield Southgate

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POST-ITS FROM PRACTICE

A LEVEL PLAYING FIELD

Effective treatment starts with a meaningful partnership, says **Dr Steve Brinksman**

Gary had been in and out of treatment for years; he knew more about substance use and misuse than most doctors and he knew it.

We recently had a new doctor join our practice who had worked elsewhere for a number of years. I was chatting to her about how she was settling in and interested to hear that she felt the biggest difference was that we were a genuine partnership working together, whereas where she worked previously she'd felt that she'd been a partner in name only.

This led me to ponder on the many occasions we are in situations with clients that are essentially unequal in terms of who holds the power, and how this can cause dysfunctional relationships. Sometimes this is due to pushing back against perceived authority, and sometimes from complete passivity – neither of which is likely to produce the best outcomes.

Gary had been in and out of treatment for years; he knew more about substance use and misuse than most doctors and he knew it. However he also frequently used on top, was in and out of prison, and was hep C positive. He had dropped out of treatment with the community treatment agency about six months before registering with us.

The first time we met I let him talk, and the second and probably the third and fourth as well, then gradually we started to explore what had happened in his life and what he really wanted. By now he was on 60mls methadone and still using heroin and crack a couple of times a week. I was keen that he increased his medication dose to see if we could stop the on-top use; he wasn't.

Despite his bravado and subject knowledge about street drugs it became apparent that he had very low self-esteem and that this was tied in with his poor literacy. We have an excellent adult education college in Birmingham and with a little encouragement he eventually contacted them and started a course to improve this.

The change in Gary was profound. He started to develop real confidence, rather than just a front. He met people who had struggled like him, and who like him were looking to make a positive change. He stopped his own 'use on top' without ever agreeing to an increase in medication dose.

I thought I knew what was needed for Gary from a medical perspective, and yet what was really needed was for us both to form a real partnership where he had the confidence to talk openly about what mattered to him and I listened and helped him achieve his goals.

Whatever our professional role may be, the balance of power seems heavily stacked in our favour by those we see. We need to realise this and make an extra effort to develop meaningful partnerships that facilitate change rather than impose it.

Steve Brinksman is a GP in Birmingham, clinical lead of SMMGP, and RCGP regional lead in substance misuse for the West Midlands.

He will be speaking at the DDN Conference on 22 February, www.drinkanddrugsnews.com/ddn-conference-2018

RESOURCES CORNER

Listening to the service user

The informative messages of a 'user's view' DVD are as pertinent now as a decade ago, says **George Allan**

While 'voices of recovery' are now being heard, less has been forthcoming in recent times from service users about their experiences of the system. While the findings of controlled trials must remain the basis on which treatments are provided and services designed, it is critical that these are enhanced with the views of the service user.

Although it was produced over a decade ago, what the five people interviewed in the DVD *Substitute Prescribing: the user's view* (Exchange Supplies and The Alliance) have to say remains highly relevant. The title is a misnomer: ostensibly the film presents their opinions of methadone but underneath this is a commentary on what makes a good service. We cannot hear these messages often enough. I have watched the DVD a dozen times and I continue to learn from it. While extremely valuable for sparking discussion with inexperienced practitioners and students in a range of disciplines, experienced workers should watch it: it provides a check list of best practice.

The messages are simple but profound, and can be grouped under headings:

THE CHALLENGE OF CHANGE. Trying to stop using is hard but with each attempt the person will learn more. Prescribers need to appreciate that, in the process of weaning onto OST, some continued use is likely. A struggling service user can lead to a worker becoming fed up – an attitude that the person will soon pick up.

PERSON-CENTRED SERVICES. Services may state that there is choice but, in reality, some offer limited options and restricted prescribing. One services user describes how strange he felt when an agency asked him, 'What do you want?' The importance of counselling beyond key working is stressed.

ACCESS. While this has improved since the film was made, the need to 'jump through hoops' to obtain certain services often remains. The service users talk of 'continually having to prove yourself'.

DROPPING OUT. One bad experience of a practitioner or service can lead to a person disengaging for a lengthy period. Waiting for specialist services is another factor. These issues are particularly pertinent in the light of increasing rates of drug deaths and the need to retain the vulnerable in treatment.

This only gives a flavour of the range of issues the service users explore in a film that is enhanced by their personal optimism and humour.

The DVD is available at www.exchangesupplies.org

George Allan is the author of Working with Substance Users: a Guide to Effective Interventions (2014; Palgrave)

• On his last Resources Corner, DDN would like to thank George for his insightful contributions and wish him well as he retires as chair of the Scottish Drugs Forum (SDF).

Commissioning for CHANGE

An independent expert faculty has been set up to consider a vital new approach to commissioning. **Mark Gilman**, **Paul Musgrave**, **Niamh Cullen**, **Terry Pearson** and **Chris Lee** explain the context and the plan of action

Important progress in developing services for managing problematic opioid use has transformed the outcomes for people with serious drug problems. This has been achieved through a balance of innovation and careful allocation of resources.

Coming together as a group of commissioners with extensive experience, we needed to look at the pathway leading to these successes, to enable us to review the challenges facing us today. Our aim was to define questions that are central to the ongoing development of care.

This pathway to developing opioid dependence treatment may be divided into a series of stages, with defining characteristics:

Initial problems related to heroin

The 1950s saw increasing non-therapeutic opiate use, a trend which continued to grow throughout the 1960s. Early strategies to address dependence focused on prescribing opioid agonist medicines, with methadone a common and effective choice for many. Residential rehabilitation centres were set up following relatively unsuccessful results with outpatient treatment.

Key questions for commissioning

1. PLANNING BASED ON INDIVIDUAL NEEDS
How can commissioning approaches assist providers in planning high quality support, by skilled staff, for groups with different aims, goals and characteristics? How can we improve outcomes while focusing resources effectively? We need to consider introducing case management functions and systematic commissioning for mutual aid.

2. NEW THINKING AND INNOVATION
Consider how commissioning can build in new thinking to services which may reduce the need for resources directed to managing misuse and diversion risk, and ensure efficiency in medicines delivery – for example, by using innovative product formulations of opioid agonist therapy, which may not require resource intensive use of dispensing services or supervised consumption.

3. INTEGRATION AND COLLABORATION
Can commissioning ensure that specialist services better align with partner services (mental health, housing, social services, probation, police, justice, etc), to avoid duplication, create efficiency and improve continuity of care? Can we align competencies systematically so that the right skills are used most efficiently?

4. USING THE RIGHT MEASURES
How can commissioners ensure a complete holistic assessment of impact, including real world measures of health, wellbeing, crime, safeguarding and resource utilisation? Commissioners need to make decisions based on insights from a broad set of outcome measures.

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It is important for commissioners to consider how innovation can play a role in continuing to improve care, while balancing budgets... understanding the balance between innovation and organisational change is key in this instance.

Exponential growth of the problem

Treatment approaches emerged in the 1970s. Prescribed methadone doses were often challenged and inpatient treatment duration limited in response to increased demand and financial pressures. Subsequent explosive growth of problem drug use in the 1980s and 1990s led to a resurgence in 'maintenance prescribing' and introduction of on-site dispensing facilities with supervised consumption. Treatment availability and coverage were lower than they are today, locally governed, commonly led by NHS specialists and funded to provide services in a relatively limited capacity.

Expansion in treatment

The National Treatment Agency was established in the 2000s with the aim of addressing the increasing problem of heroin use by improving treatment availability and reducing waiting times. More resources and organisational change gave rise to a competitive provider market, while new models of care were designed with an emphasis on performance management. Innovative thinking led to a step change in successful outcomes for people with problematic opioid use.

Evolution: a shift in focus

Recently the incidence of new heroin use has reduced. The existing cohort of approximately 150,000 people remains engaged with treatment services, with potentially greater needs related to comorbidity. The treatment system and method has evolved: policy has promoted focus on recovery-oriented and abstinence-based approaches, and concurrent mental health disorders have received greater attention. In parallel a step-down in resources has occurred in many locations, placing stronger focus on the need to achieve efficiency and cost-effectiveness in providing services.

Challenges today

While funding for treating opioid-related disorders is decreasing in many areas, there has not been an equivalent change in working practices to compensate. At the same time, drug-related deaths have been increasing in all four nations, linked to the ageing population and also unexplained factors. In many cases, services are essentially delivering less of the same, which is keeping the system 'ticking over'. Looking to the future, it is relevant to consider if services are achieving the impact the population needs and deserves. And in parallel, how can we focus on innovation to maintain continuing improvement in outcomes?

There are a number of areas of innovation: use of digital technologies to provide psychological interventions, different forms of opioid agonist medications, and options to better address comorbidities such as hepatitis C virus (HCV) infection. It is important for commissioners to consider how innovation can play a role in continuing to improve care, while balancing budgets. There is already evidence of a new group of injectable opioid agonist therapies from various pharmaceutical companies which, if approved for prescription in UK, may allow treatment to be delivered with injections weekly or monthly.

Current spending with community pharmacies on medications, supervised consumption and dispensing is substantial. There may be opportunity to restructure services to allow direct supply of medications or on-site storage at clinics, allowing resources to be redirected. Understanding the balance between innovation and organisational change is key in this instance.

Evolving treatment options pose questions about the different ways in which therapy is tailored to the needs of the individual. In some cases, medications for opioid dependency are used chaotically as part of a wider cocktail of drugs; for others it is part of a long-term fluctuating but largely stable lifestyle, while for some it is a tool to help achieve recovery or abstinence. Do the services we commission build treatment systems with the ability to tailor interventions to the individual?

Questions may focus on whether all parts of treatment are employed to best effect – particularly psycho-social interventions. Do the treatment services we commission make the best use of the right kind of quality psychological and social therapies?

Considering future optimisation, commissioners should consider the readiness of the workforce providing care. Is the workforce appropriately skilled, and could a smaller number of competent staff be more efficient and effective? Is comprehensive training, supervision and support provided?

Collaboration is also key to future success. Do care pathways remain largely isolated from parts of the public sector that serve the same target audiences? Greater integration with mental health and housing services could help to reduce duplication.

Equally important is the approach to measuring performance. Do the outputs we measure as a part of the commissioning process tell us enough to improve health and wellbeing, while reducing offending and safeguarding fears?

Addressing questions such as these is key if continuous improvements in treatment and social outcomes are to be delivered while managing the balance of resources – an essential equation for commissioners in achieving continuing improvements in outcomes for all.

This article represents the authors' personal views.

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One year on, an alliance of 13 NHS trusts is gaining momentum in addressing the failings of the sector and developing more effective pathways to care, as **Danny Hames** explains

A MORAL IMPERATIVE

The NHS Substance Misuse Providers Alliance (NHSSMPA) has been in existence for just over a year. NHSSMPA is a collaboration of 13 NHS trusts, all of which provide substance misuse services in the community and prisons. While NHS provision has changed in the last few years and just over a quarter all community substance misuse treatment systems are NHS, we continue to provide inpatient detoxification facilities nationwide and work in numerous prisons. Celebrating 70 years of the NHS, and in this time working with those affected by drugs and alcohol, means it is in our DNA.

Our aims are to work more closely as NHS providers, and with our colleagues in the third sector, to improve outcomes for service users through sharing and developing practice and to offer policy makers engagement with the NHS substance misuse community.

What unites NHSSMPA is a belief that people deserve high quality services which can improve their lives. For us, this means a competent and qualified workforce where volunteers complement but are not relied upon; interventions that are evidence based and individualised; that we are effective partners and contributors to a local health and social care economy; and that we protect the safety of our service users while walking alongside them to provide the best chance of recovery.

The impact of the abstinence vs harm reduction debates of the last few years, leading directly and indirectly to some some individuals being pushed through treatment systems too quickly, has been over-simplified and dangerous. Thankfully, NHSSMPA believes the new drug strategy and the presentations accompanying this have underlined a change in tone. For us as NHS providers, harm reduction has always and continues to be a priority.

There is (quite rightly) a very prominent debate regarding the reduction in funding for substance misuse services, and of course NHSSMPA strongly believes that services should be adequately funded. However, we should not let this mask the fact that recently doubt has been cast upon the governance and quality of the sector.

The emphasis on ensuring we are competent and thoughtful guardians of funding, and that this properly benefits service users, has never been more important. Local authorities are experiencing significant challenges to their budgets and there are numerous patient groups deserving of funding. So there is a strong moral imperative to use the monies we receive effectively, most importantly because:

1. We are seeing the highest levels of drug-related deaths since records began. In 2016 this numbered 2,593 deaths associated with drug misuse.
2. Recovery rates are dropping for opiate users. In 2011-12 treatment completion was 8.59 per cent; year to end November 2017 it was 6.7 per cent (NDTMS). This is all despite a narrative underpinning many procurement exercises that service redesign will mean improved performance.
3. The CQC's recent review of non NHS residential was shocking – 63 per cent of services were assessed as not meeting the regulation on 'safe care and treatment' (CQC).
4. The unfortunate demise of Lifeline, a charity with an income of £53m, demonstrated poor organisational governance and left more than 5,300 potential creditors, including other charities.

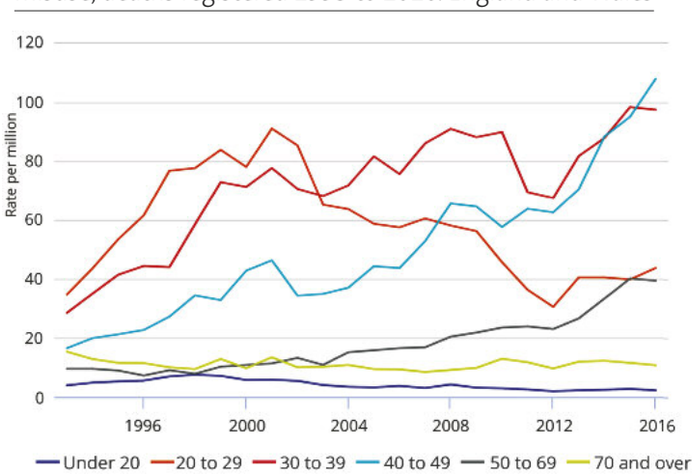
> 'The impact of the abstinence vs harm reduction debates of the last few years, leading directly and indirectly to some some individuals being pushed through treatment systems too quickly, has been over-simplified and dangerous.'

NHSSMPA is highly committed to advocating for appropriate funding, but we must not ignore that there have been very significant indications that the sector needs to improve its governance and outcomes for patients. NHSSMPA organisations have a public service and moral duty to achieve this. Over the coming years NHS providers will make our contribution and commit our expertise, because justifying the effectiveness and quality of what we offer has never been more necessary.

Danny Hames is chair of the NHS Substance Misuse Providers Alliance

If you are a NHS trust and would like to find out more about NHSSMPA please contact candie.lincoln@sssft.nhs.uk

Age-specific mortality rates for deaths relating to drug misuse, deaths registered 1993 to 2016. England and Wales

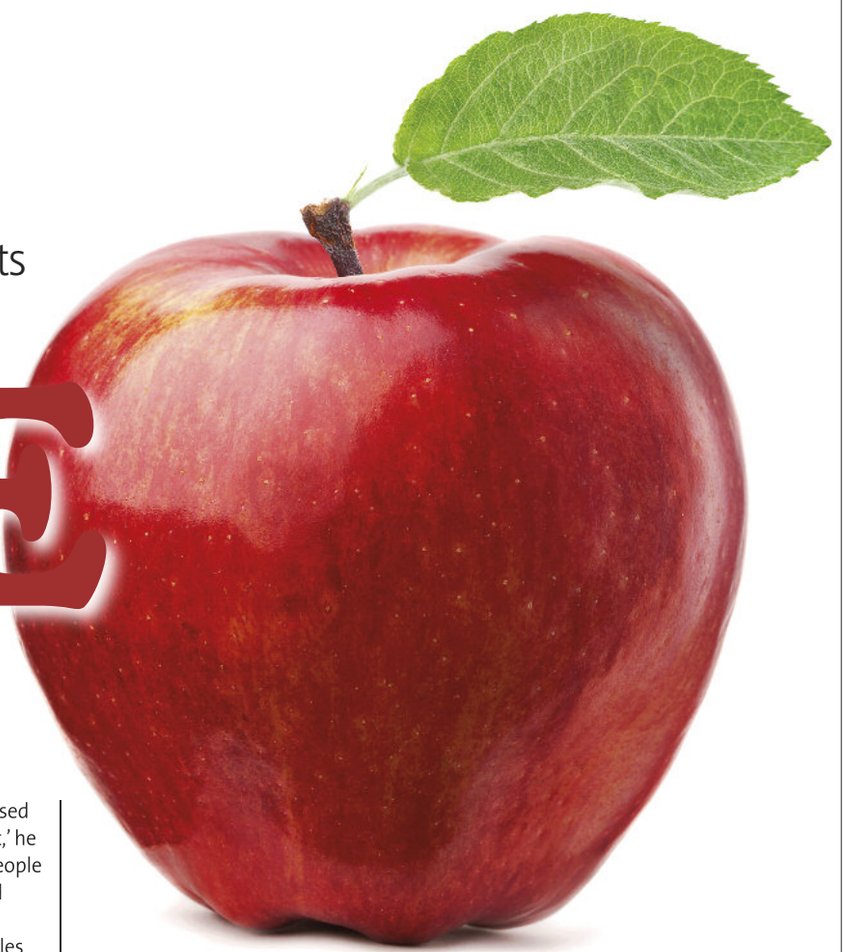


Source: Office for National Statistics

More on alcohol at:
www.drinkanddrugsnews.com

Time is of the essence in overhauling the alcohol strategy, says the Drugs, Alcohol and Justice APPG. **DDN** reports

RIPE for refreshment



'We were asked by government, "what should be in the alcohol strategy?",' said Dr Richard Piper, chief executive of Alcohol Research UK – a question he passed on to the Drugs, Alcohol and Justice Cross-Party Parliamentary Group.

The last alcohol strategy was in 2012 and last year's drug strategy 'only made passing reference to alcohol', he pointed out. But Public Health England's 2016 evidence review had shown that there was a large pool of evidence from which to draw.

'Any alcohol strategy should be developed with health inequalities in mind,' he said. It should also be impact based and 'clear about the difference we are trying to make'.

The strategy had to aim for reductions in alcohol-related attendance at A&E, mortality, and crime, said Piper. Its content should have three key themes – support and interventions; the consumer side; and 'other', which included considerations such as drink driving.

Children and families needed to be central to considering interventions – 'both as victims and part of the solution'. Mental health was also a critical part. 'We need to understand more about dual diagnosis,' he said. 'When does mental health trigger a problem and vice versa?' He also reminded the group that the cost of not treating people was much higher than treating it.

On the consumer side, minimum unit pricing (MUP) was evidence based and necessary. 'Evidence supports it,' he said. 'Saying "let's wait and see if people die" is indefensible.' Advertising and sponsorship should no longer be targeted at young people; online sales should be addressed (including very easy alcohol sales on eBay); local communities needed to be able to get involved in licencing decisions more easily; and alcohol labelling should be revised to include ingredients, calories and information about health harm.

Alison Douglas, chief executive of Alcohol Focus Scotland, took up the issue of MUP. Scotland intended to implement minimum unit pricing imminently she said, adding 'it is not a standalone policy, it is part of a package of measures'. Three things stood out – price, availability and marketing – and it was clear that a 'whole population approach' was needed.

'There's a huge cost in misery and loss of life years and the impact is felt by all of us,' she said. 'It's not just a health problem, it's fundamentally undermining the fabric of society.'

The logic behind focusing on MUP was that it was an 'exquisitely simple and targeted measure'. 'It's not based on any one product, but applies to all premises that sell alcohol and targets the cheapest high-strength alcohol,' she said. In answer to the argument that MUP penalises the poor, she said that they were most likely to benefit: 'Harmful drinkers in the poorest groups are the ones most affected by MUP.

'We want to see it extended to all of the British Isles because of the benefits to public health and communities,' she added.

> 'We need to understand more about dual diagnosis. When does mental health trigger a problem...'

Julie Breslin brought her experience as head of Drink Wise, Age Well, a lottery-funded programme led by Addaction, which helped people over the age of 50 to make healthy choices.

The aging population of the UK consumed more alcohol than other age groups and 'must be considered in any strategy refresh', she said. Harmful attitudes relating to alcohol were increased by living alone, chronic illness or disability, while contributory factors could be retirement, bereavement and lack of a sense of purpose as people got older. The long-term health impact of drinking too much was 'significant'.

The treatment sector was failing to respond to the needs of this age group, Breslin reported. Three-quarters of rehabs had an arbitrary age cut-off and there was 'a perception that you can't teach an old dog new tricks'. The new strategy should incorporate age as a cross-cutting theme, with an advisory panel convened to give guidance, she said.

The benefits of the Drink Wise, Age Well programme were illustrated by Vince, who shared his personal story. 'I've always enjoyed a drink with colleagues and friends,' he said. 'Then I was signed off work with ill health and this was when drinking became more of a problem. I used it to cope with pain. I saw my GP, and while we discussed the need to cut down my drinking, he didn't refer me for help.'

Being referred to Drink Wise, Age Well led to being referred to a detox unit, followed by support at home. Peer support meetings became a 'crucial part' of his recovery and he became a volunteer helping to facilitate them.

'If it wasn't for support, I wouldn't have had the strength to do it on my own,' he said. **DDN**

THE RIGHT FOCUS

An effective review of commissioning will need input and inspiration from everyone involved – practitioners, commissioners, and especially those using services. **DDN** reports

There have been many calls for a review of commissioning practice as budget cuts have sliced through services and severely curtailed treatment capacity. So the newly formed Expert Faculty on Commissioning's consultation (page 10) is certainly timely.

'The financial squeeze on drug and alcohol services will seriously undermine the quality and effectiveness of services,' says Annette Dale-Perera, chair of the ACMD Recovery Committee, which at the end of last year announced that the commissioning structure needed an overhaul (*DDN*, November, page 7).

The faculty's review offers key questions for commissioning, asking how we can ensure skilled staff are providing high quality support, incorporate innovative thinking, make sure that services are well integrated with partner support services, and consider whether we are using the right outcome measures.

The question of staff skills and training is being addressed by the Federation of Drug Alcohol Practitioners (FDAP), which is now administrated by SMMGP. Interim executive director Kate Halliday explains that FDAP has been developing an apprenticeship for the sector to drive up standards. A 'trailblazer group', including major employers in the field, is putting forward a proposal to the Institute of Apprenticeships for a Drug and Alcohol Practitioner Apprenticeship level four qualification.

The standardisation of training for drug and alcohol practitioners represents an exciting time for workforce development in the sector, says Halliday: 'We can hope to see an improvement in the provision of services, the retention of staff and the encouragement of new talent to the field.' FDAP hopes that the first apprenticeship courses will be ready for roll-out in 2019.

The question of adopting more innovative commissioning practice depends on 'a fluid dialogue between commissioners and those at the front delivering the services,' believes Yasmin Batliwala, chair of WDP – whose organisation, alongside Blenheim and Addaction, supports the Drugs, Alcohol and Justice Cross-Parliamentary Group. The group's recent Charter for Change called for the creation of a national commissioning ombudsman to address failures in commissioning practice.

'By establishing firmly this culture of transparency, the often-byzantine process of allocating funding is made that little bit simpler,' she says. On the one hand commissioners are put at ease, safe in the knowledge that the money is going to dedicated experts and professionals, and on the other, it instils confidence in the providers on the front line, ensuring that they remain valued and supported.

Blenheim's interim chief executive, Deborah Jenkins, acknowledges that innovation is difficult when commissioners are under such huge pressure to do the best they can, with continuing levels of disinvestment against a rising number of service users. She sums up the 'lose-lose situation for commissioners, providers and most importantly service users', as 'tenders are issued where it is just not possible for even the leanest organisation to deliver'.

'Commissioners are facing extremely difficult choices about where to cut back,' she points out. 'Do they cut back on needle exchanges, which are perhaps an easy choice but which would lead to wider public health risk of an increase in blood-borne viruses such as HIV and hepatitis C? Do they try to commission innovative digital services which, while largely unproven, are cheaper than face-to-face services and don't require the overheads of premises? Do they decommission the wrap-around employment, training and education programmes that are designed to help people integrate back into society, sealing that final step on the recovery journey, and without which relapse is highly likely? Or do they cut back on children and young people's services, where the interventions have the greatest possible lifelong impact for service users and their families?'

There is no easy answer, she acknowledges, as all these services are crucial in providing highly effective drug and alcohol support services. But her suggestion is that commissioners think laterally, focusing on the return on investment to the wider economy. And yes, she believes there is scope for a more innovative approach.

We need to ask ourselves whether there are better ways of commissioning drug and alcohol services, she says, such as 'commissioning jointly with CCGs who are responsible for mental health, with police for prevention of drug and alcohol-related crime, and with housing departments.

'The same vulnerable and high-risk cohort of people appear in the pathways across all these organisations, so let's take a people-centric approach and a joined-up view of how to address the problem and complexity surrounding substance misuse.'

The question of integrating services has to take service user involvement as its starting point, believes Tim Sampey, founder and chief executive of the peer-run service user charity Build on Belief.

A lot has changed in service user involvement in the past decade, with peer-led initiatives springing up all over the country – 'Build on Belief and the FIRM in London, Red Rose Recovery and the Recovery Republic in the north of England, SUIT in the Midlands, to name but a very few,' he says.

'In the past couple of months, the importance of these service user initiatives

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It's a lose-lose situation for commissioners, providers and most importantly service users as tenders are issued where it is just not possible for even the leanest organisation to deliver...

has been the focus of both the APPG Complex Needs and Dual Diagnosis *People powered recovery* report and the EMCDDA paper, *User-led interventions – an expanding resource*? But where do they sit in the commissioning framework?'

In too many instances, peer-led initiatives are not written into the tender specification at all, he says – or if there are, they are levered into service provision as 'added value'. In such cases, the specification is often 'so fuzzy it risks becoming meaningless', with the vast potential to add valuable layers of peer support and aftercare completely missed.

The practice of 'whole system commissioning' excludes many peer-led organisations with strong track records, who are formally constituted as CICs or charities, from taking part in the tendering process unless they can subcontract their services to a major provider, he points out. He acknowledges that some of the big treatment providers have been highly supportive of such organisations over the past few years, but adds 'the buy-in is not universal, and there are those who think it both cheaper and less risky to keep everything in house.' And while some projects are directly commissioned by local authorities, ensuring their independence, 'this practice is not as widespread as it should be,' he says.

Sampey does, however, have news about a different approach that he hopes will become more widespread. 'In the past year, two small contracts were put out in Southwark and Medway separately from the main service provision tender, with the specific intention of attracting smaller, bespoke organisations,' he says. 'It's too early to say if this is the beginning of a trend, or an exception to the rule, but such initiatives are far-sighted and welcomed.

'I've also heard stories, mostly from the Midlands and the north of England, of commissioners protecting small peer-led initiatives by making it clear that they must be supported by whichever main provider wins the contract,' he adds.

He sees this as good practice. 'Successful peer-led initiatives take time and commitment to design, implement and grow, and like roses are difficult to revive if allowed to wither and die. Clearer provision for them in overall tender specifications, smaller bespoke commissioning, and protection for existing services in whole system commissioning would go a long way to ensuring that a lot of the effort, innovation and creativity put into the wider service user involvement agenda over the past decade is not lost.'

As Sampey points out, working with service user networks is invaluable in informing consultation documents and strategy papers around complex needs. An important factor in getting this right is to connect effectively with the many other support services, rather than commissioning for substance misuse as a separate entity.

'The drug strategy acknowledges that the drug strategy in isolation can't deliver the changes that most people need in their lives – the need to incorporate changes around employment, accessing mental health and physical health services, offending, domestic violence, and caring for your children,' says Paul Hayes, head of Collective Voice and former head of the National Treatment Agency (NTA). 'Drug treatment makes a vital contribution to all of those things, but in isolation won't address any of them.'

Commissioning will need to be informed by broader measures than relying solely on the Treatment Outcomes Profile (TOP), he points out. 'Just as a whole range of services need to be available to people with drug and alcohol problems, so outcome measures need to reflect what's happening to people's lives with broader communities, within all of these domains,' he says. 'TOP is an excellent way of identifying the progress an individual is making towards addressing a number of those issues, but in isolation can't tell the whole picture about the impact of drug misuse, or its cumulative impact, along with other services, for whole communities.'

The DDN conference on 22 February will give the opportunity to get involved in the commissioning consultation. More information and booking at www.drinkanddrugsnews.com

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PARTNER UP

Co-production and partnership working can help organisations thrive in troubled times. **DDN** hears from the MD of Equinox Care and Penrose Criminal Justice Services, Kelly Hallett

'As a sector we can still do more to work together to find better or more innovative ways of pooling resources and supporting people,' says Kelly Hallett. 'Certainly one of my priorities is to identify more opportunities for us to be building these relationships and combining expertise.'

Joined-up working is a subject she knows quite a bit about – late last year she was appointed MD of Equinox Care and Penrose Criminal Justice Services, both of which are part of the Social Interest Group (SIG), which was established as a charity in 2014. 'At the time Equinox was looking for a merger partner and Penrose wanted to build a much stronger infrastructure, which it couldn't afford on its own,' says Hallett. 'SIG was the answer.'

The group now includes five charities, and provides the framework to support them and help develop their strategies. This means organisations can remain true to their charitable aims and retain their own boards while benefitting from being part of a 'much bigger picture', she explains. 'It's about strengthening our charities by opening up opportunities to freely learn from each other and innovate, working closely together and remaining financially robust enough to enjoy the back-office services that they could not have achieved on their own.'

> 'It's about strengthening our charities by opening up opportunities to freely learn from each other and innovate.'

The new MD role offers the opportunity to 'lead two charities as businesses that truly care about individuals' recovery and rehabilitation', she says. 'I have great ambitions for Equinox, Penrose and our service users.' She'd worked at Penrose for more than six years, rising to director of operations and director of criminal justice services, before taking on the current role. Before was Turning Point – first as regional manager for Kent and then assistant director for substance misuse – and before that a period in prison drug treatment. 'I started as a volunteer, progressing to CARAT worker, CARAT manager and then eastern area manager, overseeing 11 drug treatment services in prisons across the East of England,' she says.

So was the drugs sector something she'd always been interested in? 'Not specifically. I always knew I'd work with vulnerable people and I always had an interest in prisons. Many years ago I worked with the elderly, then I had a temp job in a prison doing admin which gave me the opportunity to be introduced to the prison substance misuse team. I started volunteering with them in 2003, which led to a job within the team – this field has captivated me from day one, and I'm still very grateful to have been given that volunteer position.'

Drug treatment in prisons is obviously facing hugely challenging times, with the consequences of the dramatic increase in NPS use making regular headlines. What could be done to improve treatment provision in the current climate? 'I think that whilst there are some excellent examples and outcomes out there, there are still many challenges to providing effective, choice-based treatment,' she says. 'The cuts to funding and staffing are well known, and the environment itself is restrictive – prisons are facing their own challenging times. Access to, and movement of, prisoners is not always easy, and prison regimes often mean that it's hard for meaningful activity to take place – boredom and lack of daily structure can be very demotivating.'

Despite all the evidence showing that 'safe environments improve outcomes', access to specific resettlement, wellbeing or drug-free wings isn't always an option,

More on partnership working at www.drinkanddrugsnews.com

she points out. 'And we need to think about where we locate offenders post-treatment within a prison setting.' Healthcare-led models can also dilute the emphasis on treating substance problems, she adds. 'The focus on overall wellbeing is welcome – we know that offenders will almost always have many needs – but it does mean that there are fewer opportunities for intensive treatment for offenders. I think every positive outcome achieved in a prison is a testament to the skill and dedication of the support provider.'

In terms of the specific challenge of NPS, their use has changed the prison landscape 'significantly, if not completely', she states. 'There isn't an easy answer. Availability is high, it's difficult to detect, and it makes an already difficult environment even harder in terms of treatment and – from a prison perspective – control.'

Education around the risks and effects needs to be dramatically stepped up, she stresses, with the allocation of dedicated resources alongside more action to interrupt supply. 'It should be a top priority – the introduction of NPS has created the perfect storm, and I don't think we saw it coming in time to be anything other than reactive.'

A key concern that predates the NPS crisis is the crucial period immediately after release, when the risk of overdose can be high. What kind of support should organisations be putting in place? 'We know from experience and data that the take up of treatment post-release is lower than anyone would like, and there are many ways it could be improved,' she says. 'We're still in the position where a great many offenders across the country walk out of the gate on release alone, and that can be scary – no matter how many appointments have been made – and transition between support and/or treatment agencies can be particularly hard for some.'

Many prisoners will have multiple needs to address, and little support when it comes to safe and positive influences – just trying to navigate services can feel overwhelming. While peer support and 'meet at the gate' services can undoubtedly be effective they remain underfunded, and those that do exist struggle to meet the demand. 'A true through-the-gate model that holistically supports offenders through that first few weeks would be welcomed by many agencies,' she says. 'Then there are the challenges of working effectively with someone who may only be in prison for a few weeks, or remand prisoners who come and go so quickly and yet can have the highest needs.'

> 'When women feel safe and are appropriately supported they achieve greater independence and higher self-esteem.'

Our current sentencing system also means we're 'still sending far too many offenders to prison for short periods', she says, which mainly serves to 'disrupt already unstable lives further'. Far more people would benefit from intensive drug and alcohol treatment, mental health treatment or both, she states. 'I am determined for Penrose Criminal Justice Services to successfully develop and promote alternatives to prison for this cohort – and we haven't even touched on the need for safe and secure accommodation.'

When it comes to populations whose needs have traditionally been under-served by the sector perhaps the most obvious is women, and part of her remit was to set up a residential complex needs service in Brighton, which opened last month. How important are specialised services like this in the sector? 'There's such a need for female-specific services,' she says. 'Demand for our service is high, and that's just three weeks in. These services are essential, and there need to be more. We've been able to create a safe, female-only environment, and all of the evidence shows us that when women feel safe and are appropriately supported they achieve greater independence and higher self-esteem.'

> 'We could be working together in a much more powerful way to influence and deliver real change in the sector.'

The women in the service have 'multiple and very complex needs,' she continues. 'Lots of emotion, lots of trauma – domestic violence and exploitation is a prevalent need – and all of our residents have chosen our service because it's female only. That speaks volumes in itself. Women in our service are able to articulate themselves away from stigma, away from control, and reflect. They're supported with all individual needs within the service, including those who have children, and what we can't provide ourselves we bring in. Brighton has some amazing partnership working, some of the best that I've seen anywhere – there's clear progression within the service towards independent living and this gives our women hope. I definitely plan to develop more female-only services in the near future.'

As someone whose experience covers substance use, offender services, mental health and more, how far has genuine joined-up working become a reality? 'I think things have improved, but there's still a long way to go,' she says. 'Again, there's a mix of examples in the field, from excellence to non-existence. It's always troubling when we meet service users who have failed in recovery or resettlement simply because they couldn't navigate, or find cohesiveness between, community support services. Just a few months ago I was talking to a service user who had had eight assessments from different services in ten days. Is this really where we still are?'

The flipside of that is the excitement that comes with seeing great services or innovation, however. 'I come away thinking "I want that!"' she says. 'It's not always reflected in data – what I want to see is the tangible impact. I hope that one day health and social care can be used in the same sentence in a much more meaningful way. They're all too often miles apart.'

The answer ultimately lies in 'truly joining things up solely to the benefit of service users, co-producing services and improving access using their experience – they really do know best', she states. 'To see that across the board would be phenomenal. It's actually one of the biggest strengths of the Social Interest Group – we have all of that expertise under one umbrella and we can work in a very cohesive way to offer more joined-up services, but it's more than just us.'

So what sort of strategies should the voluntary sector be adopting generally in these challenging times? 'Co-production and partnership working – there are so many great organisations out there, and many examples of organisations really strengthening their offerings to service users by joining forces.' Funding keeps going down while demand keeps going up, and there's 'still a lot of duplication in what we do and how we do it', she says. 'We could be working together in a much more powerful way to influence and deliver real change in the sector – both locally and politically. We're so good at what we do – our voices should be heard more.' DDN

Should e-cigarettes be provided free to smokers who cannot or will not quit, asks **Neil McKeganey**

FREE TO BREATHE

WHILE SMOKING RATES HAVE STEADILY DECLINED in recent years, there are still around 9m people smoking in the UK and approximately 120,000 smoking-related deaths per year. Although tobacco control has been one of the highlights of global public health, the challenge of further reducing smoking prevalence becomes harder, not easier, over time.

Those smoking now are doing so in the face of the known harms of smoking, decades of smoking bans, graphic health warnings, tax hikes on tobacco products, age restrictions on the sale of tobacco products, advertising bans and widespread social opprobrium directed towards smokers. If the UK is going to succeed in further reducing smoking prevalence it is going to have to do something radically different to what it has done in the past. One thing the government might now consider is providing smokers with free access to e-cigarettes.

E-cigarettes have been characterised by Public Health England as at least 95 per cent less harmful than conventional cigarettes. We know from research in the US that smokers using e-cigarettes are more likely to have attempted to quit, and that those quit attempts are more likely to have been successful. There is also growing evidence that providing smokers with access to e-cigarettes has a beneficial impact, even if those smokers have not previously committed to quitting. Recent research from the University of South Carolina, for example, found that nearly a third of smokers provided e-cigarettes for free had reduced their smoking by at least 50 per cent over the three-month period the researchers were monitoring them.

> Nobody is suggesting that e-cigarettes are harmless

Nobody is suggesting that e-cigarettes are harmless, but if they are much less harmful than the alternative and can have a beneficial impact – even for smokers not already determined to quit – why aren't we doing all we can to reduce the barriers to vaping? Charging smokers a price for using e-cigarettes is one of the barriers that is starting to look decidedly inappropriate.

There is an inverse relationship between smoking and deprivation, with the highest levels of smoking, and the highest levels of smoking-related harm, found in the poorest communities. There is probably nothing that would have a greater impact on reducing health inequalities than reducing smoking among the poorest sectors of society. On that basis it makes no sense to attach a financial barrier to smokers' access to e-cigarettes – especially where that barrier is going to be greater in the communities where levels of smoking are at their highest.

Providing free e-cigarettes to smokers who cannot quit, or who will not quit, may be the equivalent of investing millions in flu vaccinations or providing statins to those at risk of future health problems. These are programmes that are funded in the expectation of future savings. There are few savings greater than those that can be achieved by reducing smoker numbers. The cost of providing smokers with free access to e-cigarettes may be a cost that is easily justifiable if it results in a further reduction in smoking prevalence.

Dr Neil McKeganey is director of the Centre for Substance Use Research, Glasgow

CLINICAL EYE

Facing the inevitable

The death of a client can hit you like a ton of bricks – unless you are prepared, says **Ishbel Straker**

2017 BROUGHT ME MANY SURPRISES; some have been amazing, some a whirlwind of negativity, but all have been an opportunity to reflect and learn. My biggest revelation was death – not the fact that people die, but our differing experiences of it as nurses within the addiction field.

Throughout our nursing training we make the assumption that we will experience death – some being more traumatic than others, some needing hands-on experience and others that we see from a distance. We may then go on to believe that working in the field of addiction – where clients place themselves at risk daily and allow physical deterioration – our mental preparation for the experience of death will improve.

Making these assumptions is dangerous and will leave you unprepared for the reality. Shock and grief are odd things and as nurses we are not immune to them. Our clients are different – yes, they are risky and yes, death at times seems like an inevitability – but our role as nurses is to prevent this, so when it happens there can be a lot of blame attached.

We become close to our clients – boundaried, but emotionally invested in them. We want them to succeed and we believe that they will. If we did not have this belief system we would not be doing the job we do, but it leaves us vulnerable to the emotions that come with their death. All of this is made far more stressful by the inevitable, and of course necessary, root cause analysis (RCA), unearthing fears of possible Nursing and Midwifery Council (NMC) involvement even when there is no cause for concern. We are trained to think, 'what could I have done differently?' and these thoughts can be incredibly negative if left to fester.

So how do we safeguard our ability to cope with death? I believe the first step is to have a robust system to manage this after the event – supervision, reflection, and perhaps a group debrief to ensure the focus remains on the client and their family members, to maintain some perspective. It's also to ensure any RCA systems and investigations do not have a punitive feel but are supportive, and most importantly it is to admit that we are not immune to grief, shock and fear when a client dies and understand that all the preparation in the world will not prevent it hitting you like a ton of bricks.

Our reactions are not just about the death of this client, but about the deaths that have gone before – in both our professional and personal lives. Our reactions can also be about where we are emotionally at that time. Of course, as nurses we are all 100 per cent professional all of the time – but it's good to remember that we are still only human.

Ishbel Straker is a clinical director, registered mental health nurse, independent nurse prescriber and board member of IntANSA

DDN WELCOMES YOUR LETTERS

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

'There were 950,000 Americans reporting heroin use in 2016, but that number is dwarfed by the number misusing prescription opioids, at 11.5m...'

QUADRUPLE BYPASS

America's opioid epidemic has been big news for a while now, but amongst all the headlines and documentaries and think pieces one issue seems to be consistently overlooked – and it's an issue that's a bit of an inconvenient truth for the ever-more powerful and vocal legalization lobby. According to the US Centers for Disease Control, the number of drug overdose deaths rose from just under 17,000 in 1999 to nearly 67,000 in 2016 – i.e. it quadrupled. And according to the presidential commission on the crisis, 'not coincidentally' the level of opioid prescribing quadrupled over the same period (*DDN*, September 2017, page 5).

There were 950,000 Americans reporting heroin use in 2016, but that number is dwarfed by the number misusing prescription opioids, at 11.5m (*DDN*, November 2017, page 5). What's more, according to a recent *Economist* article on a major study of the crisis, a huge number of these deaths are happening in relatively affluent communities, rather than the populations usually decimated by drug harms. 'The epidemic is caused by access to drugs rather than economic conditions,' it says.

So the only conclusion to draw from all this is that the argument endlessly trotted out by all the usual suspects – that a legal, regulated market would drastically reduce levels of harm – is, as many of us have always said, utter nonsense.

Paul Bennett, by email.

PEDANTIC SEMANTICS

Despite no longer working in the field, thank God, I like to keep up with the latest pronouncements of the thought police, and so it was with increasing incredulity that I scrolled through the Global Commission on Drug Policy's new report about language and stigma (see news, page 5).

All very laudable in intention, obviously, but in it we learn that there was a 'moral panic' about crack use in the US in the '80s and '90s, based on a 'misconception' that use was 'exploding'. That this was a 'misconception' may come as surprise to people who lived in deprived American inner city areas during those years, but what do they know, eh? A bunch of rich people in Switzerland are happy to put them right.

My favourite part, however, is the table on page 30 that explains which language is OK and which is no longer acceptable. 'Drug user', bad; 'Person who uses drugs', good. 'Drug habit', bad; 'Substance use disorder' or 'Problematic drug use', good. Not to be pedantic, but according to the commission's own criteria aren't 'disorder' and 'problematic' more stigmatising than the innocuous-sounding 'habit'?

'Recreational, casual or experimental user' are all bad, we discover, and instead we must use 'person with non-problematic drug use' (trips off the tongue). That's in order to distinguish them from – and therefore stigmatise, I'd venture – someone with 'problematic' use. Then it starts to get truly deranged. Despite being used by almost every agency I ever encountered, 'opioid replacement therapy' is now unacceptable, and you would be a *fascist* to use it, while 'opioid substitution therapy' is fine. So that's that cleared up then.

It's also good to see commission member Nick Clegg offering his opinions on all this in the pages of the *Guardian* and the *Mirror*. One can't help thinking, however, that if he was so concerned about the welfare of drug users – sorry, *persons who use drugs* – perhaps he should have thought twice before enabling a Tory government that went about slashing treatment budgets to the bone.

Molly Cochrane, by email

MEDIA SAVVY

The news, and the skews, in the national media

2018 is already a watershed in global drugs policy. Cannabis is partially legal in most US states; Canada will follow soon; Germany, France and Italy are all reviewing policy... When you consider what a green wave could do for Britain – freeing police and court time and saving lives, as well as unleashing innovation, raising revenue – our approach seems absurd. The only people who benefit from the current situation are criminals. Instead of a safe, regulated market we are awash with psychotic skunk controlled by violent gangs.
Richard Godwin, *London Evening Standard*, 3 January

There's appetite to reform the UK's drug laws, but it has to be done right. The public are ahead of politicians, with recent polling showing that more people support a legal, regulated cannabis market than oppose it. The government's silence on this crucial issue is deafening.
Daniel Pryor, *Guardian*, 18 January

In this climate of punitive neglect, addiction and obesity are dismissed as diseases of choice, which to use that most class-bound of Tory insults, the 'nanny state' cannot cure. It's true that breaking free from heroin, alcohol or sugar requires an effort of individual will. It is equally true that it is easier to summon the strength to quit when others are on hand to help. These truths ought to be self-evident. But they are not evident in Britain.
Nick Cohen, *Observer*, 7 January

Lazy stereotypes also let us off the hook when we really should be getting to grips with the deeper social issues that are the cause of problematic drug use. One reason people use drugs is to cope with difficult life circumstances. People who have been through trauma or abuse are more likely to find their drug use leads to dependency. These are people who need our support – they don't need to be labelled, condemned and pushed further away.
Nick Clegg, *Mirror*, 10 January

With many medical schools failing to include addiction in their curriculum this sends a clear message early on in doctors' medical careers that patients with drug dependence problems don't matter... The derogatory language we use to describe people who use drugs is merely a symptom of a deeper problem. The danger of adopting a new vocabulary while retaining the same values and attitudes is that we sound more accepting but really nothing has changed from the patient's point of view. I hope I am wrong.
Ian Hamilton, *BMJ*, 17 January

A STEP TOO FAR?

Have we been right to embrace the 'cycle of change', asks **Natalie Davies**

When Bill Wilson, who went on to co-found Alcoholics Anonymous, was hospitalised for the fourth time for alcohol detoxification, he cried, 'If there is a God, let Him show Himself!'. As AA's story goes, 'the room became ablaze with light and Wilson was overwhelmed by a Presence and a vision of being at the summit of a mountain where a spirit wind blew through him, leaving the thought, "You are a free man". Wilson never took another drink.'

Though Wilson's story is spectacular – so much so that we might be inclined to think it a 'fable' rather than a blueprint for what might actually happen – it's not unusual to hear about 'revelatory moments' or moments in which someone suddenly or spontaneously discards a substance that up to that point they had depended on. An example is the smoker who suddenly becomes disgusted with their smoking, spits out the cigarette half way through, dumps the remnants of the packet in a bin, and never turns back, as if something had overtaken them.

But another important narrative, and perhaps one more pertinent to the conversations between practitioner and client, is of the 'longer road to recovery' – of a process of change rather than a one-off event; of an experience mixed with conflict, ambivalence, vacillation, regret, and often relapse. And it's this process that Prochaska and DiClemente's ubiquitous 'five stages of change' model endeavours to describe.

The 'five stages' plot the journey from Point A ('no acknowledged problem') to Point B ('no problem now') – each marker along the way representing a shift in motivation, intention, and capacity to change. Dealing frankly with the possibility of relapse, the popular depiction of the five stages as a 'cycle of change' (see the illustration opposite) shows the continued work that people can do or redo until the day they successfully achieve what is known as a 'lasting exit' to recovery. The cycle shows the progression or evolution through the stages of pre-contemplation, contemplation, preparation, action, and maintenance, and how this can come full

circle due to (re)lapse. It doesn't exclude anyone from the process – even 'not thinking about the harmful behaviour' or 'not being sufficiently aware of the health implications' is a stage in itself.

As well as broadly describing change, the five stages provide a means of separating people into groups. From a practical perspective, if, as its originators have suggested, each stage entails 'specific unique tasks that need to be accomplished in order to move successfully to the next stage', the model has the potential to explain and even help generate behavioural change. It acts as a guide to what to do (or not do) with clients at different stages of change – for example, avoiding wasteful change attempts with those not yet ready to change, and recognising when someone is ready to commit to treatment; or if not, how to nudge them towards a more receptive stage.

The model was originally based on a comparison of smokers who were considered 'self-changers', versus those in professional smoking-cessation treatment. Although later applied to, and tested on, a range of other health-related behaviours including harmful drinking and drug use, smoking still accounts for the bulk of studies.

Whether the model would be deemed a success in the field of substance use (even if for now we are primarily relying on studies of smokers) depends on how we judge 'success' – on the model's ability to help us understand the process of recovery, or its ability to help clients progress along the road to recovery. If the latter, the key test is the performance of so-called 'stage-matching' strategies which deliver different interventions suited to the assessed stage of the client.

An assessment for the UK's National Health Service concluded that 'Overall, whilst there is some evidence favouring the use of stage-based interventions for smoking cessation compared to no intervention, there is little evidence that stage-based interventions are more effective than non-stage-based interventions.' Similarly, the verdict reached for the Cochrane Collaboration was that 'Expert systems, tailored self-help materials and individual counselling, appear to be as effective in a stage-based intervention as they are in a non-stage-based form'. In other words, across relevant studies, it could not be shown that matching to stages led to more non-smokers.

The most stringent test of 'stage-matching' would be to provide exactly the same interventions, but at random, to either match or not match these to stage of change. Of the studies reviewed for the Cochrane Collaboration, the most promising found that generally smokers whose computer-generated feedback and advice matched their stage were more likely to progress to the next stage, but were not necessarily more likely to successfully stop smoking.

Whether the model would be deemed a success in the field of substance use depends on how we judge 'success' – on the model's ability to help us understand the process of recovery, or its ability to help clients progress along the road to recovery.

Unfortunately, it seems that at the 'crunch point' – when the model actively engages with change through treatment or brief interventions – research support is largely absent. The best the American Psychological Association could say on the matter was that matching interventions to stage of change was 'probably effective' – and looking at the relevant review, even 'probably' is optimistic. Could this indicate that there is something flawed about the stages themselves? That the way they are characterised lacks validity?

The underlying idea that motivation and intention to change increase over time and with each stage is a valid one – studies have found strong positive associations between both these variables and the five stages of change. So, we're clearly in the right ballpark. But these strong positive associations could also indicate that we are dealing with a continuum of change, rather than a stepped pattern of change – meaning that the five stages may not be 'true stages' at all, but 'pseudo stages' picked at arbitrary points along a continuum. If this were the case, and definitive evidence emerged to debunk the idea of stages, would this be enough to dismiss the whole model? Or as a tool for discussing recovery, is it useful in itself to be able to refer to stages as symbols of progression, whether or not they constitute discrete experiential or emotional states?

The cycle of change itself was only one part of a broader model of behavioural change proposed by its originators. Other 'relatively neglected' parts of the model have addressed the mechanisms that explain how people navigate change, including the ten common processes of change (eg consciousness-raising, self-re-evaluation, and helping relationships), weighing up the pros and cons of changing, and confidence in one's ability to change and avoid temptation. But it's the cycle of change's ability to translate a complicated, daunting experience into something tangible for people both inside and outside the substance profession, that has arguably made this the most eye-catching aspect of Prochaska and DiClemente's work.

Until something comes along to displace the cycle of change from our substance use language, perhaps it should continue to be embraced for what it does rather than rejected for what it does not – first and foremost, helping to understand and visualise the process, milestones, and emotional labour involved in recovery.

Jargon is commonplace in the sciences, but relatable language is not. And as a means to starting a conversation, the cycle of change isn't bad. As a way of keying interventions to the client's condition, on balance it has yet to be proven beneficial.

Natalie Davies is assistant editor at Drug and Alcohol Findings, http://findings.org.uk

THE CYCLE OF CHANGE

BALANCING ACT

A new project is helping steroid users to recalibrate their lives while providing evidence for better treatment, says **Jody Leach**

At Open Road we launched a project – Steroids, Weights, Education And Therapy (SWEAT) – in 2017 in direct response to the growing number of steroid users accessing our needle exchange programmes across Essex. SWEAT is funded by The Big Lottery and tackles the increasingly complex needs of those using image and performance enhancing drugs (IPEDs). The service is based in needle exchanges, where steroid users are first identified, and offers support to those who are using, thinking about using, or have previously used IPEDs.

We work alongside local gyms and pharmacies to promote our SWEAT contact points, but the project goes way beyond generic needle exchange provision. We ensure access to specialised psychosocial interventions, harm minimisation programmes and educational resources to dispel myths and promote understanding of the potential side effects and long-term harm of IPED use.

Our project guides clients through post-cycle therapy (PCT), good diet and nutrition, training regimes and sleep, to support them in making informed decisions about steroid use. A combination of one-to-one sessions with specialist workers and formal in-house counselling allows them to explore their motivators for using and the impact this lifestyle could be having on their mental health and relationships.

SWEAT is a three-year project and will be formally evaluated in collaboration with the University of Essex, with the intention of informing IPED-specific service provision at both local and national level. In April we will be running a conference, 'A Shot in the Dark', to bring together experts, practitioners and support services to learn, inform and share their expertise in IPEDs and to hear about the impact of our project in its first year of operation. Among the speakers will be Prof Jim McVeigh, director of the Public Health Institute at Liverpool John Moores University.

'The use of anabolic steroids and other IPEDs amongst the general population is now a recognised public health issue,' he says. 'However, there are few services providing and evaluating interventions for this population. While some of those beacons of good practice remain, others have fallen victim to the current funding crisis. The SWEAT Project is an exception and an important development, not just for the population it serves, but in generating evidence of effectiveness.'

There are many health implications associated with IPED use, with physical risks ranging from superficial harms such as acne and balding, through to sexual dysfunction, cardiovascular disease and impaired liver function. Injecting-related harms are a potential feature of steroid use, with site swelling, abscesses and exposure to blood-borne virus infection being possible. Users' mental health can be impacted in varying degrees, with changes in mood, levels of aggression and an impact on general psychological wellbeing relating to existing body image and/or self esteem conditions.

'IT HELPED ME HELP MYSELF'

Most other services just give you your needles, but SWEAT actually listened, says Justin

JUSTIN WAS A LONG TERM STEROID USER. During 20 years of use, he recognised that steroids were having serious negative effects on his life but he was afraid of letting go of the habit and he didn't know how to stop. In particular he feared damaging his relationship with his wife and young family, if his image changed.

Justin constantly feared losing respect from his children – they were proud of his hulk like figure, often asking him to 'show off his muscles' to their friends – and he was afraid of how they would feel about him if he stopped using steroids became just an 'ordinary dad'.

He also felt that his steroid abuse was affecting his libido but did not know how to tell his wife for fear that she would feel it was her fault. He had been using steroids for so long he feared that, even if he stopped now, it was too late for his testosterone levels to return to normal and he worried about any withdrawal effects on his mental health. Justin knew he got the short term boost from steroids he needed, but he also realised it was time to stop.

Justin discussed his options with the SWEAT worker and we looked into ways to boost testosterone naturally through diet, workout regimes and mind-set.

We then looked at how to reduce his dependency and eventually cease his current cycle of behaviour. We discussed what his side effects or 'come down' may be, to prepare him.

As Justin's testosterone levels started re-balancing, he was ready to cope

‘IPED users rarely view their behaviour as being similar to users of other substances. This mindset results in many users being reluctant to access any formal treatment services...’

IPED users rarely view their behaviour as being similar to users of other substances. This mindset results in many users being reluctant to access any formal treatment services outside of generic needle exchange programmes. Consequently, IPED users are less likely to recognise and acknowledge, let alone address, the potential risks and behavioural issues associated with this group of substances.

Jody Leach is SWEAT project manager and quality coordinator at Open Road

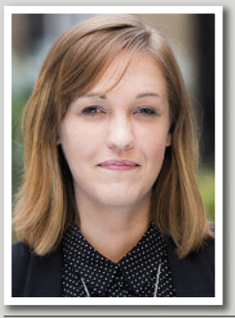
with the low moments and he stuck with the programme. A new healthy diet and workout regime meant, to Justin’s surprise, that his testosterone levels began to return to normal after a few months – he even kept most of his ‘pumped-up’ physique.

He also conquered all the self-doubt and re-built his self confidence. His relationship with his wife is now more honest and fulfilled, his children are even prouder of their father, and he spends more time with them now because he is no longer obsessed with weight training. And he’s no longer feeding dodgy suppliers with cash that should be spent on his family.

‘SWEAT is the first service that actually listened to my needs and understood the difficulties behind my steroid misuse,’ he said. ‘Most other services just give you your needles and don’t ask how you are.

‘The team gave me hope and helped me help myself into a sensible diet and fitness routine, and I would probably still be using now with no way out, if I hadn’t found them.’

LEGAL EYE



Nicole Ridgwell answers your legal questions

HOW DO WE PROVE OUR SERVICE USER INVOLVEMENT?

We are disappointed with the results of our recent CQC review – one of the things we were marked down for was not involving our clients in planning their care. We dispute this as patient involvement has always be central to how our service operates. How can we compile evidence to back up our challenge?

To launch an effective challenge, providers must understand the parameters of the process itself. With CQC draft inspection reports, challenges should be made through the factual accuracy process, through which the provider has ten working days to submit a response from the date of receipt.

It is important to note that CQC factual accuracy guidance implies that providers can only challenge facts. That is wrong as a matter of law – CQC must take into account all written representations about the inspection process and the content of the report. It may be, for example, that a provider agrees that specific documentation error occurred but does not agree with the inspectors using that isolated example to conclude that the service has systemic failures in record keeping.

Factual accuracy representations must be as detailed as possible. When we draft responses, we scrutinise the draft line by line; identifying not just factual inaccuracies but negative or imprecise wording and vague criticisms. This level of detail is necessary to ensure that providers lodge all valid objections. Should matters progress to enforcement action, it is much more difficult to retrospectively challenge something about which providers were initially silent.

For a successful challenge, providers must provide evidence to rebut the criticisms, where possible using CQC’s own language. It is much harder for CQC to ignore a challenge where a provider demonstrates compliance with CQC’s own guidance.

In our question, the touchstone would be CQC’s *Better care in my hands: a review of how people are involved in their care*, which ‘can be used by providers... to understand what CQC expects to see when we regulate how well services involve people...’.

Where possible, therefore, the evidence gathered will explicitly align to CQC’s own examples. In this case:

- *personalised care plans – written with people, for people, and with their wishes and preferences clearly identified and monitored*
- *the sustained and supported involvement of families and carers in the care of their loved ones*
- *the coordination of people’s involvement in their care as they move between services*

A strong challenge will cross-reference provider polices and policy implementation. Care plans, patient notes, minutes of family meetings and patient reviews (to name potential sources) will demonstrate how patients are involved at every stage of care planning and show the outcomes of that involvement.

In preparing for any challenge, success is in the detail. Sweeping criticisms are rebutted only by specific, consistent evidence of best practice compliance. Compiling the evidence may therefore be painstaking and protracted in the short term, but a successful challenge which restores your service’s reputation will always be worth it in the long run.

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

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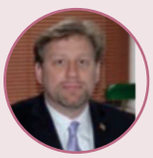
EVENT SPEAKER HIGHLIGHTS

MIKE TRACE AND JAC CHARLIER

CRIMINAL JUSTICE DIVERSION INTO DRUG OR ALCOHOL TREATMENT - HOW ARE WE DOING?

For over 20 years, a key UK drug strategy objective has been to identify people with drug problems in police stations, courts and prisons, and encourage them to accept treatment to address their addictive and criminal behaviours. Over the same period in the US, there has been widespread development of Drug Courts that have the same objective.



This session will consist of a panel conversation and facilitated discussion between Mike Trace (Former UK Deputy Drug Czar, and current CEO of Forward Trust) and Jac Charlier (Director of PTAC - a US coalition of agencies promoting pre-trial diversion) that addresses the following questions:

- To what extent, with hindsight, were these policies and programmes well implemented.
- Did they achieve their objectives of reducing drug related offending, and getting more people into recovery?
- Are the current mechanisms for diversion working well?
- What should happen next - in the USA and the UK?

DR GORDON MORSE, DR CHRIS FORD AND NIAMH EASTWOOD

GLOBAL DRUG POLICY UTOPIA – GROUNDED IN THE PRINCIPLES OF HUMAN RIGHTS, NOT MORAL PANIC

The attempt to control drug use and harms through punitive sanctions (i.e. the war on drugs) has been a global failure. In fact, in many cases it has intensified the problem, leading to soaring prison populations, and disproportionately pulling poor, vulnerable or minority communities into the dragnet of the criminal justice system.

Negative perceptions and fears of the general public, reinforced by negative media portrayals, have made drugs and people who use them an 'easy target' for politicians and other elected officials who want to curry favour with their voters.

In this impassioned panel discussion, leading activists from the most influential groups will explain the reasons such failure was predictable and illustrate how decriminalisation policies (as pursued in other countries such as Portugal and the Netherlands etc) offer a rational and more humane way forward, that also have huge economic and research gains for society.

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DR TIM LEIGHTON AND GRAHAM BEECH

CLOUDS IN THE COMMUNITY

Tim and Graham will explore how addiction treatment has evolved since Clouds first opened its doors in 1983, and how the impact of austerity and changes to the regulatory environment challenge traditional notions of rehabilitation and call for new approaches in the creation of communities of recovery. Drawing on evidence of effectiveness, this presentation will examine the respective roles of residential treatment, community-based approaches, and mutual aid in supporting sustainable recovery.

PROFESSOR DAVID NUTT

PSYCHEDELIC ASSISTED PSYCHOTHERAPY – NEW NEUROSCIENTIFIC APPROACHES TO ADDICTION AND DEPRESSION

The world is entering a new phase of psychiatric treatments. After the psychotherapy and medical treatment phases in the last century, we are at the start of the phase where we use drugs to assist and empower psychotherapeutic processes. The origins of this exciting new development are the massive growth of neuropsychopharmacology, particularly in relation to the use of psychedelics (e.g. LSD, Psilocybin) and entactogens (e.g. MDMA). New research on the impact of these drugs on brain functions show clear impacts on brain processes that contribute to maladaptive behavioural processes. Parallel research has shown efficacy for psilocybin and MDMA in disorders such as resistant depression and PTSD. In this ground-breaking talk, Professor Nutt will cover these remarkable new developments and show how they may be used more broadly in psychiatry/psychotherapy in the future.

DR PRUN BIJRAL

REDUCING THE IMPACT OF A FENTANYL OUTBREAK IN THE COMMUNITY

Fentanyl is now hitting the headlines in the UK. The drug is not so well-known this side of the Atlantic but, if experiences in America are anything to go by, that will change. Sadly, fentanyl is a problem that is unlikely to be going away. Fentanyl and its analogues range from highly valued medicines to highly dangerous synthetic opioid drugs with little or no legitimate use in humans. The painkiller and anaesthetic is 50 times more potent than morphine, is powerfully addictive, fatal even in tiny amounts, and has become a huge part of America's opioid crisis. Change Grow Live (CGL), the UKs largest drug and alcohol treatment provider has launched a new report and action plan to mitigate the threat from fentanyls. DR Prun Bijral will discuss improving awareness of prevalence and being able to rapidly identify a possible outbreak which could be critical to supporting effective overall management.

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TENDER

CONTRACT FOR A BUCKINGHAMSHIRE CHILDREN AND YOUNG PEOPLE SUBSTANCE MISUSE SUPPORT SERVICE

Buckinghamshire County Council (BCC) is redesigning the children and young people substance misuse support system in Buckinghamshire. The new service will be a combined tier 2 and tier 3 that will work across the whole of the county. The new service will commence on the 1st October 2018 and will include innovative harm reduction, brief advice and information, drop in facility, structured support, links with Early Help and Safeguarding, Hidden Harm support.

BCC will be running a tender process during this year and the resulting contract will be awarded for an initial period of four years with the option to extend it further by up to two years. Extension options will be dependent on performance and subject to ongoing available funding. The value of the contract will be circa three hundred thousand pounds per annum.

The Council is of the opinion that Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) may apply to this contract.

The Council is holding a Provider Information Event in relation to this tender on Tuesday 30th January 2018 10am – 1pm , BCC, Exhibition Suite Room 1, Market Square, Aylesbury.

We would like to invite interested parties to attend the event which will include:

- *Information about the substance misuse needs of children and young people in Buckinghamshire*
- *Information on the new service model*
- *Information on the strategic direction for children and young people substance misuse prevention work*
- *An opportunity to meet commissioners*
- *Information on the procurement process including key dates*

To book a place at the Provider Information Event please email **rcarlile@buckscc.gov.uk**. Please note that due to limited space we can only accommodate two people per organisation For any general questions regarding the event contact **Becky Carlile** on **01296 387061**.

Attendance at the Provider Event will not give any advantage to potential bidders nor will your organisation be disadvantaged by not attending the event. All information provided at the Provider Event will be published on the Buckinghamshire Business Portal (the Portal) at **www.supplybucksbusiness.org.uk**

*The Council uses the Portal to advertise tender opportunities and run its tender processes. To access the tender documents you will need to register on the Portal at www.supplybucksbusiness.org.uk. We anticipate that the tender documents will be published on the Buckinghamshire Business Portal in **February 2018**.*

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