DRINK AND DRUGS NEWS

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CONTENTS

4 NEWS
Increase hep C testing say MPs; Trump calls for death penalty for drug dealers.

6 STRONG ARM OF THE LAW
PCCs lead the way in call for drug policy reform.

8 CLIMATE CHANGE
It's time to bring a DCR to Belfast, says Chris Rintoul.

10 LETTERS
Unwanted interventions; Commissioning controversies.

11 CLINICAL EYE
Don't neglect yourself, says Ishbel Straker.

11 MEDIA SAVVY
The news, and the skews, in the national media.

12 ALL OR NOTHING
Is 12-step setting some people up to fail, asks Alex Boyt.

14 MAKING PATHWAYS
How do commissioners tackle increasingly complex issues with less money?

16 A NEW FRONTIER
Treatment needs to reach out to different groups, argues Paul North.

EDITOR'S LETTER

'With yet more evidence, can we justify standing still?'

How far do you have to go to show that something's a good idea, it's cost effective, and that it works? We know that safe spaces, such as DCRs, save lives and that supporting instead of punishing is the only humane approach to drug policy.

When leaders on the frontline of law enforcement raise their voices to tell us our current approach to drug policy is not only failing, but a 'crazy waste of money', surely politicians must listen (page 6). These are not isolated voices: the Royal Society for Public Health is among many organisations to back harm reduction initiatives such as consumption rooms and heroin-assisted treatment as a move towards evidence-based policy.

Police officers were among the stakeholders to come together at a recent conference In Belfast on injecting drug use (page 8), and talked about the damage that law enforcement approaches can do to vulnerable people. If the support of the local police force is a critical factor in being able to establish DCRs in the UK, then surely we can't be far off making them a reality in local areas.

We're all too familiar with the upward trends in drug-related deaths, so when we're presented with yet more evidence that a policy change would be cost-effective as well as health-effective, how can we justify standing still? And with police, local government and the health and social care fields calling for a move from evidence to action, surely it's time for every region to be clear and purposeful in getting on with it.

Claire Brown, editor

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

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

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

Reporter: David Gilliver
e: david@cjwellings.com

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

Designer: Jez Tucker
e: jez@cjwellings.com

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

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NEWS

STEP UP TESTING TO MEET HEP C TARGET, SAY MPS

'SIGNIFICANTLY GREATER' numbers of people need to be tested, diagnosed and treated in order to eliminate hepatitis C, according to a report from the All Party Parliamentary Group (APPG) on Liver Health. England needs to agree on a national elimination strategy if it is to make the most of a 'once in a generation' opportunity to eradicate the virus, the group stresses.

The report is the result of an inquiry by cross-party MPs and peers, in which expert contributors 'overwhelmingly agreed' that England is currently not on track to achieve either the NHS target of eliminating the virus by 2025 or the World Health Organization target of elimination by 2030. 'The upcoming deal between NHS England and the pharmaceutical industry must include innovative new measures to find those still living with hepatitis C and engage them into treatment,' says the APPG.

The report urges the government to 'express its explicit support' for the elimination agenda, and make sure that the agreement between the NHS and industry includes ambitious national and regional targets, as well as mechanisms to make sure funds are distributed 'equitably'.

Funding pressures on local authorities are having a negative impact on testing and prevention initiatives, says the report, while levels of awareness among the public and even primary care professionals remain low. Many of the 40-50 per cent of the estimated 160,000 people living with the virus who are still undiagnosed are 'part of vulnerable populations with chaotic lives', it adds, while 'overly complex' care pathways are still creating barriers to accessing treatment.

The report calls for treatment to be 'universally accessible' and available in community settings, as well as the introduction of 'opt-out' testing in drug treatment services, with 'commissioning contracts stipulating clear mechanisms to hold services to account' for failing to meet targets.

Last month's *Get Connected* conference heard how CGL's hep C strategy was focusing on 'the huge cohort of people who could benefit from testing and treatment' in drug treatment services to make the maximum impact (*DDN*, March, page 6).

'Much as there has been great progress, as this report makes clear, we all need to up our game,' said Hepatitis C Trust chief executive Charles Gore. 'No one should be walking round with a virus that could give them liver cancer. No one should have to wait for treatment. No one should die from this disease when we have these miraculous drugs. We can eliminate this virus so let's get on with it.'

'Finding those still undiagnosed and living with hepatitis C should be a national ambition'

SIR DAVID AMESS

'With the exceptional context of a deadly virus now being fully curable with easily deliverable, highly cost-effective medicines, finding those still undiagnosed and living with hepatitis C should be a national ambition,' added APPG co-chair Sir David Amess. 'Eliminating a public health issue that disproportionately affects some of the poorest and most marginalised groups in our society is an extraordinary and eminently achievable opportunity which should be seized with both hands.'

Eliminating hepatitis C in England at www.appghep.org.uk

'Particularly concerning is the rise in young people being exploited for sexual purposes or drug trafficking'

WILL KERR

COUNTY CRIMES

THE EXPLOITATION OF YOUNG PEOPLE by drug dealers is contributing to a significant increase in the number of 'modern slavery' cases, according to a report from the National Crime Agency (NCA). The number of potential victims of human trafficking and modern slavery reported to the authorities rose by a third between 2016 and 2017, says the agency, from 3,804 to 5,145. A two-thirds increase in the number of minors referred was due in part to a rise in 'county lines' gang referrals where young people had been 'exploited by criminals involved in drug supply', says the NCA, a phenomenon now reported by almost 90 per cent of English and Welsh police forces (*DDN*, December/January, page 5). 'What this report reinforces is that we are now dealing with an evolving threat,' said NCA director Will Kerr. 'Particularly concerning to us is the rise in young people being exploited for sexual purposes or drug trafficking.'

National referral mechanism statistics at www.nationalcrimeagency.gov.uk

PEER PROMOTION

A NEW REPORT on the Whole Family Recovery Project in Greenwich has been published by Adfam. The project empowers families to 'develop, deliver and evaluate' sustainable services in the area, creating 'visible family recovery champions' to inspire others.

Changing lives: using peer support to promote access to services for family members affected by someone else's drug or alcohol use at www.adfam.org.uk

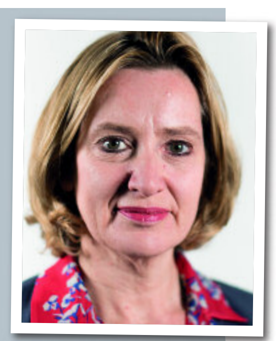
SPEAK OUT

THE GOVERNMENT IS CONSULTING on its draft Domestic Violence and Abuse Bill, which could see abusers having to undergo compulsory alcohol and drug treatment and being bound by domestic protection orders that prohibit them from drinking or taking drugs. 'This is a once in a generation opportunity to transform our entire approach to this terrible crime,' said the home secretary, Amber Rudd. 'I call on everyone, but especially those who have suffered abuse in any form, to speak out and help shape the way we approach this crime for years to come.'

Consultation at consult.justice.gov.uk until 31 May

'This is a once in a generation opportunity to transform our entire approach'

AMBER RUDD



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TRUMP CALLS FOR DEATH PENALTY FOR DRUG DEALERS

US PRESIDENT DONALD TRUMP has said that his Department of Justice intends to seek the death penalty against drug traffickers 'where appropriate under current law'. The announcement was one of a range of measures set out as part of his latest initiative to attempt to tackle the country's ever-worsening opioid crisis.

The initiative would address the factors fuelling the crisis, he said, including 'insufficient access to evidence-based treatment' as well as both the supply of illicit drugs and over-prescription by medical professionals. The number of opioid overdoses in the US has quadrupled since 1999, as has the level of opioid prescribing (*DDN*, September 2017, page 5). Trump pledged to launch a 'nationwide evidence-based campaign' to raise public awareness of the dangers of prescription and illicit opioid use, and to implement a 'safer prescribing plan' to cut opioid prescriptions by a third within three years.

He would also 'crack down on international and domestic drug supply chains devastating American communities', he said. Alongside the possible death penalty for drug dealers this would include further securing ports and land borders, shutting down illicit online opioid sales and strengthening penalties for selling fentanyl and other substances that are 'lethal in trace amounts'. The initiative would also work to ensure that 'first responders are supplied with naloxone', however, and increase access to evidence-based treatment 'as an alternative to, or in conjunction with, incarceration' for people in the criminal justice system.

'We will work to strengthen vulnerable families and communities, and we will help to build and grow a stronger, healthier, and drug-free society,' he said.

The US-based Drug Policy Alliance said that while measures such as improving treatment provision and rolling out naloxone would be helpful if there was a focus on putting the latter 'in the hands of individuals and community groups', the president had 'done little to offer a public health response' to the situation.

'Rather than helping people at risk of overdose and their families, Trump is cynically using the overdose crisis to appeal to the worst instincts of his base, and pushing for measures that will only make the crisis worse,' said executive director Maria McFarland Sánchez-Moreno. 'If this administration wants to save lives, it needs to drop its obsession with killing and locking people up, and instead focus resources on what works: harm reduction strategies and access to evidence-based treatment and prevention.'

> Trump pledged to launch a 'nationwide evidence-based campaign' and to implement a 'safer prescribing plan'

Meanwhile, visits to US emergency departments for suspected opioid overdoses increased by 30 per cent in the year to September 2017, according to the Centers for Disease Control and Prevention (CDC). The Midwest saw the largest increases, with Wisconsin recording a 109 per cent rise. 'Long before we receive data from death certificates, emergency department data can point to alarming increases in opioid overdoses,' said CDC acting director Anne Schuchat. 'This fast-moving epidemic affects both men and women, and people of every age. It does not respect state or county lines and is still increasing in every region in the United States.'

Opioid initiative briefing at www.whitehouse.gov
Vital signs: opioid overdoses treated in emergency departments at www.cdc.gov

TESTING TIMES

DRUG SAFETY TESTING SERVICES should be available to the public in 'nightlife districts', according to a report from The Loop, Volteface, the APPG for drug policy reform and Durham University. Venue staff should also be trained how to respond effectively to drug use, says *Night lives: reducing drug-related harms in the night time economy*. 'Clubs risk closure if there is a drug-related death but they also risk closure if they attempt to introduce harm reduction measures,' said co-author Fiona Measham. 'By contrast, UK festivals have been introducing evidence-based and effective measures to address the growing drug-related problems faced in the UK, including hospitalisations, deaths and contaminated supply chains. Drawing on festival drug policy and practice, this report makes key recommendations to bolster our night time economy and to protect the customers and venues within them.'

> Drug safety testing services should be available to the public in 'nightlife districts'
>
> PROFESSOR FIONA MEASHAM

Document at volteface.me

BLEAK VIEW

SIX OF THE TEN local authority areas with the highest rates of heroin and/or morphine deaths are seaside towns, according to a new ONS dataset. Blackpool, Bournemouth, Portsmouth, Hastings, Thanet and Swansea are all coastal resorts, and some 'also have high levels of deprivation, which could link to increased drug use', it adds. 'Places that may have been more synonymous with family holidays are among the ten areas that saw the highest rates of drugs misuse fatalities where heroin and/or morphine were mentioned on the death certificate.'

Figures at www.ons.gov.uk

OUT OF COURT

THE PHILIPPINES has given notice that it is withdrawing as a state party to the Rome Statute of the International Criminal Court (ICC). The ICC recently announced that it was opening a preliminary investigation into extra-judicial killings as part of President Duterte's 'war on drugs' (*DDN*, March, page 5), which is now thought to have cost around 8,000 lives. Duterte had previously announced, 'I can face the ICC – if they want to indict me and convict me, fine. I will gladly do it for my country.'

SCOT SHIFT?

LEADING MEMBERS of the Scottish Government have discussed a potential shift in policy ahead of the country's new drug strategy, which is due to be published in the summer. The government aimed to 'change the provision of treatment and support for those who are most at risk', said Public Health Minister Aileen Campbell, which meant 'taking forward evidence-led measures even if they Minister Nicola Sturgeon called for cross-party collaboration to implement 'bold and new' initiatives to tackle drug-related deaths. 'We should try and come together and be prepared to sometimes do things that may be controversial and may, in some areas, be unpopular,' said Sturgeon. 'But where there is an evidence base for them we should have the courage to do them.'

Scotland's drug-related death rate is now twice that of a decade ago and the highest in the EU (*DDN*, September 2017, page 4). Meanwhile the number of benzodiazepines seized in Scotland has almost doubled in a year, from just under 1.3m in 2015-16 to nearly 2.2m in 2016-17, according to new figures.

Drug seizures and offender characteristics, 2016-17 at www.gov.scot

Strong arm of the LAW

It used to be that senior police, like politicians, would only speak out on drug policy from the safety of retirement. These days, however, serving PCCs are taking an increasingly leading role in the call for change, as **DDN** reports

A few short years ago most people would probably not have predicted that it would soon be the police who – as Release recently said – were 'leading the way in the debate for drug policy reform' (*DDN*, March, page 5). But that's exactly what seems to be happening.

The charity was responding to the latest call by a police and crime commissioner (PCC) to implement radical measures to cut drug-related death and crime rates – in this case West Midlands PCC David Jamieson and his plans for prescribed heroin, diverting people from the courts into treatment, and 'considering the benefits' of consumption rooms.

'Despite the good work being done by many, collectively our approach to drugs is failing,' said Jamieson, whose region sees half of all burglary, robberies and shoplifting committed by people with drug problems, at huge cost to the public purse. He intends to have as many of his plans as possible in place before he leaves office in 2020, plans that also include training and equipping the police with naloxone and implementing safety-testing of drugs in the region's night-time economy.

His call had the backing of the PCCs' membership body, the Association of Police and Crime Commissioners (APPC), and follows similar announcements from North Wales PCC Arfon Jones – whose annual report included plans for a consumption room pilot and to look at decriminalisation as most drug use 'is recreational and causes no harm' (*DDN*, October 2017, page 5) – and Derbyshire PCC Alan Charles. The first PCC to put his head above the parapet, however, was Durham's Ron Hogg. It's now over a year since Hogg announced that he'd asked local public health departments to look at options for introducing heroin-assisted treatment to allow people to 'stabilise their addiction in a controlled environment' (*DDN*, March 2017, page 4), although he'd been a vocal critic of government drug policy as far back as 2014.

Initiatives such as consumption rooms, heroin-assisted treatment and drug testing in nightclubs are no longer just backed by campaigning organisations like Release and Transform, but by august bodies such as the Royal Society for Public Health (*DDN*, March, page 4 and July/August 2017, page 4) who see them as part of a logical move towards a more evidence-based policy. But why is it that increasing numbers of PCCs are calling for radical reform? The obvious answer is that it's they and their officers who are witnessing the failure of current approaches on the frontline, so it's little surprise that they might want to try something new.

This mood was very much in evidence at last month's meeting of the Drugs, Alcohol and Justice Cross-Party Parliamentary Group, which heard from Hogg, Jamieson and Jones as well as Derbyshire PCC Hardyal Dhindsa – who also serves as the APPC's alcohol and drugs lead – in a roundtable discussion on 'advancing an evidence-based approach to drug policy'.

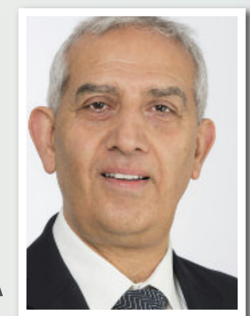
'It's time for us all to show some leadership on this – it's about us doing the right thing,' Hogg told the group. 'We cannot continue with prohibition, we're just putting millions of pounds into the pockets of organised crime. It's a crazy waste of money – policy has failed.'

In his 30 years as a drugs officer he'd seen only worsening problems, he said, and the background of constantly shrinking budgets meant that it was ever-more vital that money was spent as wisely as possible. While it was his call for heroin-assisted treatment that had unsurprisingly made the headlines, this was only 'one small aspect' of what needed to be done, he said – and one that would also help to cut out a 'pot of money' going to organised crime. 'We must not criminalise addicts, but those who deal,' he told the meeting. 'We need to treat drug users in a different way to how we do at the moment.'

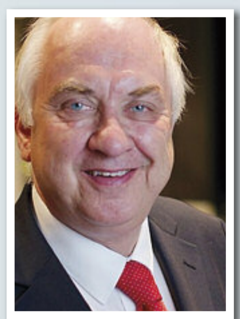
His *Towards a safer drug policy* document from July last year advocates a fundamental review of the Misuse of Drugs Act, and of UK drug policy in general. The Act's effectiveness has never been formally evaluated, it argues, 'despite

More on drug law reform at www.drinkanddrugsnews.com

The fact that the 'war on drugs' clearly isn't working has had little impact on government policy.
HARDYAL DHINDSA

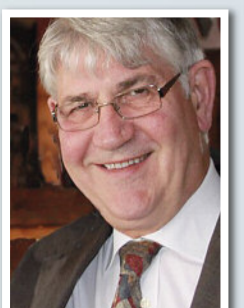


'Despite the good work being done by many, collectively our approach to drugs is failing.'
DAVID JAMIESON



'There's no difference between addiction to lawful or unlawful substances – what makes a criminal is the law.'
ARFON JONES

'We cannot continue with prohibition, we're just putting millions of pounds into the pockets of organised crime.'
RON HOGG



overwhelming indications of failure', while the current legal framework is both confusing for the public and fails to 'correlate with evidence-based assessment of relative drug harm'. Any review should also 'consider all international experiences in order to ascertain a more effective way forward', it adds.

David Jamieson's report from earlier this year, *Reducing crime and preventing harm*, shares many recommendations with Hogg's, such as diverting people from the criminal justice system, but also proposes a move that could help win over those elements of the press not traditionally receptive to drug policy reform – taking money from organised criminals to help fund drug services. 'Those profiting from the misery of drug addiction should pay for treatment,' it states.

Jamieson told the meeting that when his team had started to look at the situation in their area some 'killer facts' had emerged – not only were there more than 22,000 people using heroin or crack cocaine but 'children are affected, social services – the costs are enormous. Half of all burglary is to feed a habit, and the cost on all public services five years ago was £1.4bn – just in the West Midlands. All the shootings in my area are drug-related. It's time to have a grown-up conversation about drugs.'

The first step had been to draw up his report, he said, emphasising the links between criminality and drug harm, and the cost to public finance, and making sure it was a 'workable and pragmatic' policy document. 'We want to put it into action, and we've had enormous support – including from the media, as it talks about saving costs to the public purse.'

The main reason that the drugs issue was one that had traditionally not been led on was that it was simply seen as 'too difficult', Dhindsa told the group. The fact that the 'war on drugs' clearly wasn't working had had little impact on government policy, he said, 'but by joining up with different groups, we can make positive steps in the right direction'.

The meeting also heard from a mother whose son had been lured into 'county lines' activity by a drug gang, a growing trend that has seen a huge increase in the number of modern slavery case referrals for minors (see news, page 4). This was something that needed cross-departmental action, stressed Dhindsa. 'The issue is vulnerability – it's easy income that then becomes something much worse.'

Arfon Jones told the meeting that while as a police officer he'd only been able to make 'a small dent in the criminal business model', like other PCCs he was now in a position to genuinely influence policy. 'We need recognition that addiction is a disease and not a crime,' he said. 'We need recognition that there's no difference between addiction to lawful or unlawful substances – what makes a criminal is the law.'

Prohibition did not work, he said, as was evidenced by the fact that towns and cities were 'swamped' with new psychoactive substances (NPS) despite them having now been illegal for almost two years (*DDN*, June 2016, page 4). Regulation could not only help protect children, but help control the high potency levels found in the vast majority of cannabis currently being sold (*DDN*, March, page 5), he argued.

'We need to recognise the difference between use and misuse of drugs, and we have a way to go to recognise how important harm reduction is – people will only go into treatment when they're ready.' When it came to recreational use, however, money was 'better spent on those who have a problem', he stressed. 'Why do we punish and criminalise people who cause no harm to others? These people need diverting into an educational programme, in the same way as for a speed awareness course.'

'I'm really passionate about changing this agenda,' Hogg told the group, and while his calls for a new approach had originally met with little support, that was now changing. 'It's incumbent on those who have influence to change policies,' he said. 'I can still see their faces – when I go to tell a mother, brother or sister that someone has died. It's human misery and tragedy, and it's our duty to do something about it.' **DDN**

Climate change

Belfast's injecting drugs crisis has prompted a call for action – to bring a drug consumption room to the city as quickly as possible. Report from **Chris Rintoul**

There has been a marked rise in people who inject drugs in Belfast city centre over the last two years. This is shown by a dramatic increase in discarded injecting equipment – in back streets, car parks, public toilets, toilets provided by shops and public transport stations, as well as a number of disused buildings. Further evidence is an increase in the numbers of people begging, accessing needle and syringe provision, and presenting for treatment for heroin dependence, which has been accompanied by sensationalist media reporting and frustration among members of the business community.

On 20 February a conference was held at Queens University Belfast. Called *Responding to injecting drug use: an exploratory conversation*, it was delivered by Extern, a social justice organisation providing services throughout Ireland, and co-sponsored by Queens University and the Belfast Drugs and Alcohol Coordination Team. More than 130 people attended, from diverse perspectives and agencies including the media, politicians, city councillors and the health and social care field.

During the last two years Extern have been working with stakeholders across the city to assist in managing what has rapidly become an entrenched issue. A public expectation that Belfast's developing heroin 'scene' should, could and would be eradicated primarily by law enforcement measures is being replaced with a growing pragmatic awareness that we have to manage what is a health and social issue. As a result, attempts are being made to learn from other cities who have experienced these issues for longer periods.

'The wider public will find that the level of discarded injecting equipment reduces and visible heroin use declines.'

As Extern's drugs and alcohol consultant, I was able to use my international contacts to attract a world-class group of speakers from the legal, law enforcement, academic and practice fields. Professor Pat O'Hare of Liverpool John Moores University chaired the event, introducing the keynote speaker, Professor Carl Hart of Columbia University, NYC. Carl's impassioned presentation outlined the moral case for a baseline harm reduction response for people who inject drugs (PWIDs) in the city centre, with a drug consumption facility (DCR) in an area where drugs are already bought and used.

Next Durham's chief constable, Mike Barton, outlined his views on how similar problems in Durham could and should be treated, and made particular reference to heroin assisted treatment (HAT) for those who have not benefited from traditional OST medications. His presence attracted a number of high-ranking officers from the Police Service of Northern Ireland and enabled them to consider HAT and the case for a DCR in Belfast.

The next speakers were Niamh Eastwood, barrister and executive director of Release, and Neil Woods, an ex-undercover police officer and now chair of Law Enforcement Against Prohibition (LEAP). Niamh outlined the legal issues associated with a DCR within the UK – both the apparent barriers and potential ways to overcome them. She made clear that there is a legal way forward in the UK to the provision of DCRs, if enough popular support exists and the local police force and politicians agree with the concept.

Neil then spoke of his very personal

More on harm reduction at
www.drinkanddrugsnews.com

journey in discovering the wrongs of the 'war on drugs', especially the further damage that law enforcement approaches can do to the most vulnerable. His view is that the legal approach rarely ever reduces the supply of drugs for long and drives the market into the hands of the most vicious criminal supply networks.

*****

In the afternoon delegates heard from experts based in Glasgow, London and Dublin on issues these cities have faced in terms of responding to injecting drug use, and the serious problems faced by PWIDs in public spaces.

Kirsten Horsburgh of the Scottish Drugs Forum stepped in at the last minute for Dr Saket Priyadarshi, to inform us of the current situation in Glasgow, in light of recent advice from the Scottish Lord Advocate that any DCR in the city would require a change in the Misuse of Drugs Act (MoDA), effectively delegating responsibility back to Westminster and dashing Scottish hopes.

Dr Magdalena Harris of the London School of Hygiene and Tropical Medicine highlighted issues she encounters in her current research among homeless injectors, particularly the prevalence of skin and soft tissue infections. Then Marcus Keane, head of policy at Ana Liffey in Dublin explained the process he has been involved in to bring a change in Irish legislation, allowing for the first supervised injection facility in Ireland, which will open up later this year in Dublin.

The final session of the day was delivered by Dr Gillian Shorter of the University of Ulster. Detailing the range of DCRs worldwide, she identified different models in operation such as medically supervised or not, injection-only facilities or those which cater for people who smoke or even snort heroin, those that cater for heroin use only and those that permit the use of a wider range of drugs.

The evidence presented left us in no doubt that wherever a local need is identified, there are clear and unambiguous reasons to consider providing a DCR. The lasting impression I have is of a clear win-win-win scenario in providing DCRs – PWUDs can access a humane, health-promoting alternative to street-based injecting; support services gain an opportunity to engage with them by providing what they most need; and the wider public find that the level of discarded injecting equipment reduces and visible heroin use declines.

Charlie Mack, CEO of Extern, closed the conference with an eloquent call to action – to join together armed with the evidence we'd just heard and work to make a DCR happen in Belfast. There was a very strong consensus that we must do this, and quickly, as vulnerable lives depend on us along with our courage and determination.

A number of other cities in the UK are currently exploring the possibility of providing a DCR of some description. I believe that sooner or later one of these cities will find a way by local agreement with stakeholders in their city (rather than awaiting a change to MoDA) to provide one.

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My own thinking is that the terminology we use – 'drug consumption room' – may be unhelpful, conjuring notions of a libertarian drugs free for all. A more helpful and accurate term is overdose prevention site (OPS), which describes exactly what it is – although it is still limited in that it doesn't explain that it will allow PWIDs access to wider healthcare and social interventions such as wound care, housing and substitute opioids. Whatever the model, it will undoubtedly prevent fatal overdoses and the spread of BBVs among the people who use it. Terminology is a secondary consideration to the purpose of the service.

Extern want to build on the success of the conference in the coming months. We operate a street injectors support service, an 'old-school' harm reduction outreach service, which engages with this very hidden, vulnerable population. Since starting in October 2017, staff have successfully reversed three overdoses with naloxone, provided and removed large quantities of injecting equipment, supplied naloxone and much more. In addition, they have assisted PWIDs to access accommodation and even treatment. What if we were able to offer them an overdose prevention site as well?

We dream big, and will continue to do so until we have exhausted all options available to us to prevent the need for street injecting.

Chris Rintoul is drugs and alcohol consultant at Extern

'We did it together'

Tony Duffin describes how through local team work, a small charity helped to change the law to allow supervised injecting facilities

Established in 1982, Ana Liffey Drug Project was Ireland's first low-threshold harm reduction service. As a small charity working in Dublin and the mid-west Region of Ireland, we provide fixed site and outreach services to over 2,000 people each year and have 35 staff, supported by a similar number of volunteers.

From 20 January 2012, we were a leading advocate for supervised injecting facilities and played a key a role in lobbying for the introduction of the Misuse of Drugs (Supervised Injecting Facilities) Bill 2017 – which was signed into law on 16 May 2017 by President of Ireland Michael D. Higgins.

The following four key strategies helped us to achieve our goal of legislative change:

KNOW YOUR CASE

Gather the evidence and know the argument both for and against your proposed change. While there was only a handful of detractors, it was important to able to respond with certainty.

SPEAK TO YOUR STAKEHOLDERS' SELF-INTEREST

Don't just know who your stakeholders are, but also know what their needs are. When we communicated with different stakeholder groups, we always tried to speak to their self-interest and explain how our proposed change would benefit them.

ENGAGE WITH THE MEDIA

Engage widely and frequently with traditional media and social media. Early on we were reminded of the old journalists' saying – 'good news is not good news'. However, we had newsworthy stories which people wanted to hear. We made our own news.

ASK FOR HELP

You can't do it all on your own – we were attempting to do something that had not been done before. We asked for help at a number of key stages. At the end of the day, successfully introducing the legislation was achieved by civil society, legal, statutory and political champions all working together.

Tony Duffin is CEO of Ana Liffey Drug Project. For more info on Ana Liffey visit aldp.ie

Pictured: Catherine Byrne TD, minister of state for communities and the national drugs strategy with Tony Duffin

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

ALCOHOL

BRIEF ENCOUNTER

Alcohol brief interventions promised a way of improving the nation's public health – so what happened to this ambitious initiative? **Mike Ashton** looks back at a 27-year journey

Thank you for taking part in this project. Your screening test result shows that you're drinking alcohol above safe levels, which may be harmful to you. This leaflet describes the recommended levels for sensible drinking and the consequences for excessive drinking. Take time to read the leaflet. There are contact details on the back should you need further help or advice.

'Instead of narrow and intensive, the strategy was to spread thin and wide, deploying easily learnt interventions that could be delivered in a few minutes by non specialist staff.'

'...it's best to turn a blind eye to the "recreational" and focus instead on the genuinely problematic.'

UNWANTED INTERVENTIONS

I very much enjoyed Mike Ashton's look at the chequered history of alcohol brief interventions (*DDN*, March, page 22). My gut feeling has always been that they're at best useless, and at worst potentially counter-productive and – while I realise the jury is still out – it's nice to get even a tiny bit of academic back-up for that. And surely, they're also at odds with much of the current direction of thought around drug use, as espoused by more and more police and crime commissioners – that it's best to turn a blind eye to the 'recreational' and focus instead on the genuinely problematic.

James Burton, by email

HOBSON'S CHOICE

'Find out who your local commissioner is, and let's bring some new thinking in,' advises Paul Musgrave in your conference reports (*DDN*, March, page 12). Well I've known who my commissioner is for quite a while. The problem is he doesn't know who I am, nor does he seem to have the slightest interest in finding out, let alone listening to anything I might have to say. I realise my experience may not be all that representative, but somehow I doubt it.

'It's all about choice,' he says earlier in the article. Fine, but whose choice exactly?

Name and address supplied

PRIVILEGED POSITION

Commissioning for change* (*DDN*, February, page 10) was a good article. What is apparent in the current commissioning environment is the generalising of commissioning across local authorities, leading to poor analysis of need, poor engagement and, consequently, poor decision making. Money is being wasted on ideas rather than need, because no one connects the pieces anymore.

Partnership work, so fundamental to complex health and wellbeing cases, is best driven by a common understanding of shared responsibility and shared outcomes. That's always been difficult, made increasingly so now by fractured thinking at the very top, which has fragmented commissioning across three different structures – NHS, CCG and local authority/public health – that see themselves in competition, even if they're unwilling to admit that publicly.

The one thing I would take issue with in the article is what seems to be a focus on the effect – the use of a substance which needs to be resolved. What needs to be resolved is the causation – the background, be it peer pressure, abuse or mental health, which leads many to self-medicate, to misuse substances. How do we as people face this? By seeing each person we label pejoratively as an addict or worse, as a human being like us, someone who is a mother, sister, aunt, brother.... How do we, as commissioners, resolve this? We can't.

Only those who experience the effect can do that. Commissioners need to be able to provide the tools to assist that process. If any commissioner/authority is brave/far-sighted enough to try, distributed networks, together with 'time banking' offer some solutions for individuals to break away. As humans we all like to live in networks of like-minded people – it's easy and we're lazy. Those who are locked in a cycle of substance misuse need to be offered the opportunity to break from their homogeneous networks to ones that are more varied.

'Time banking', as envisaged by American civil rights lawyer Edgar Cahn, offers part of the solution: providing a reason to integrate, an inspiration to change. But this has to be a bold move, energising thousands, not the few, establishing communities that thrive and don't pay lip service to people's aspirations, because of local attitudes. Treatment is an adjunctive, a means by which we help people focus on their aspirations and their innate skills to move to where they need to be.

As providers/commissioners we should be privileged to work with people who have survived so much and who currently are so let down by our system.

Clive Hallam, via www.drinkanddrugsnews.com

OUT OF COMMISSION

I have been out of commissioning now for over three years. I was involved from the mid 1980s across drugs and alcohol, through the biggest wave of class A and immunological challenges.

For all the flaws of the NTA a great deal was achieved. That achievement to my mind was to a great extent driven by a sometimes unholy NHS, local authority and criminal justice alliance, but with a limited presence of user and recovery perspectives.

Mental health and housing were never really properly integrated. So some, but not enough, foundations. What happened afterwards led to the building of even more impressive new structures amid the shifts of resource to CCG and local authority and public health.

That should have meant the critical underpinning of the foundations with housing and mental health. That should have seen the structure develop new understandings between treatment and recovery. It's not just about the money – what we have is a house built on poor foundations.

The loss of the criminal justice/recovery analysis into large scale forced marriages caused by commissioning from these competing funding groups has been a disaster and threatens the legacy of what was achieved. What has been lost to me is a very simple lesson. Joint commissioning meant we all share a pot, and that pot gets used for the greater good. I am not impressed by the shared vision for physician, mental and public health, criminal justice, housing, ETE and recovery.

This expert forum (*DDN*, February, page 10) is based on collective knowledge and vision I really respect. I seriously worry whether there is just something rotten in the state of Denmark as to the new foundations of commissioning power blocs. Mental health, criminal justice and housing need to have equal status.

The woeful lack of vision to embrace the recovery movement and recovery housing – the brightest hope alongside new treatments in 50 years – risks being squandered. I wish you every success – it needed to be said.

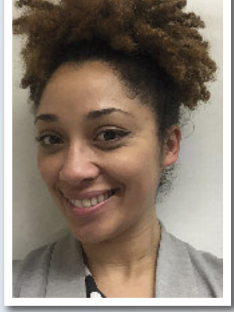
Andrew Macdonald, via www.drinkanddrugsnews.com

FIRST-NAME TERMS

I think Steve Brinksman's Post-it (*DDN*, February, page 9) is spot on in emphasising the value of treating clients as equals, and agree that doing so can be a very effective way of bolstering clients' sense of self-worth. I have found that a good way to start is by introducing myself with first and last names (as opposed to 'Dr Balfour') but sadly, in some of the places I have worked, this has been severely criticised – and such thinking may still be slightly avant-garde!

Peter Balfour, via www.drinkanddrugsnews.com

CLINICAL EYE



The best we can be

Time spent on you own development is necessary investment, says **Ishbel Straker**

It's that time of year again, when we are appraised and more importantly have the opportunity to appraise ourselves. This is a rare moment in our nursing life, but one which is incredibly valuable. We are given the space to consider how the previous 12 months have gone and how you would like things to pan out over the following 12 months for the benefit of your learning capacity and for client care.

This is a time when we can look at how best we, as individuals can empower ourselves to be the best we can be for those in our clinical spheres. I spend a lot of time thinking about this for the nurses under my care, planning out training and CPD sessions over the 12-month trajectory, considering trends within the addiction field and how we can equip the nurses to best manage them.

It is easy to look at this for others, but if you asked me the last time I considered my learning needs I would be searching for the answer. Why is that? Well, I would suggest it is because we as nurses are a selfless race of professionals. Now don't get me wrong when I say this, we absolutely have our faults and I could spend days listing them for you but I'm sure you have your own list to look at! I mean selfless because that is what we are conditioned to be throughout our training – to think of our patients before ourselves, to feed our patients before ourselves, to hydrate our patients before ourselves, to toilet our patients before ourselves.

> We cannot continue to ride on the wave of 'how we have always done things...'

Now this is all well and good. However, there are negative implications to this in the form of our own self-worth and development. We need to reflect on our abilities, the changing demographics and our competency levels within this. We cannot continue to ride on the wave of 'how we have always done things', but instead become focused on innovation – which means, as difficult as it may feel, looking inwardly at our own learning potential.

I appreciate that there are financial and time constraints within services, but this year, at appraisal, be prepared with your own ideas and personal development plan. Be what you may feel is a little selfish, because I promise, in the bigger picture, the client is still at the centre.

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

MEDIA SAVVY

The news, and the skews, in the national media

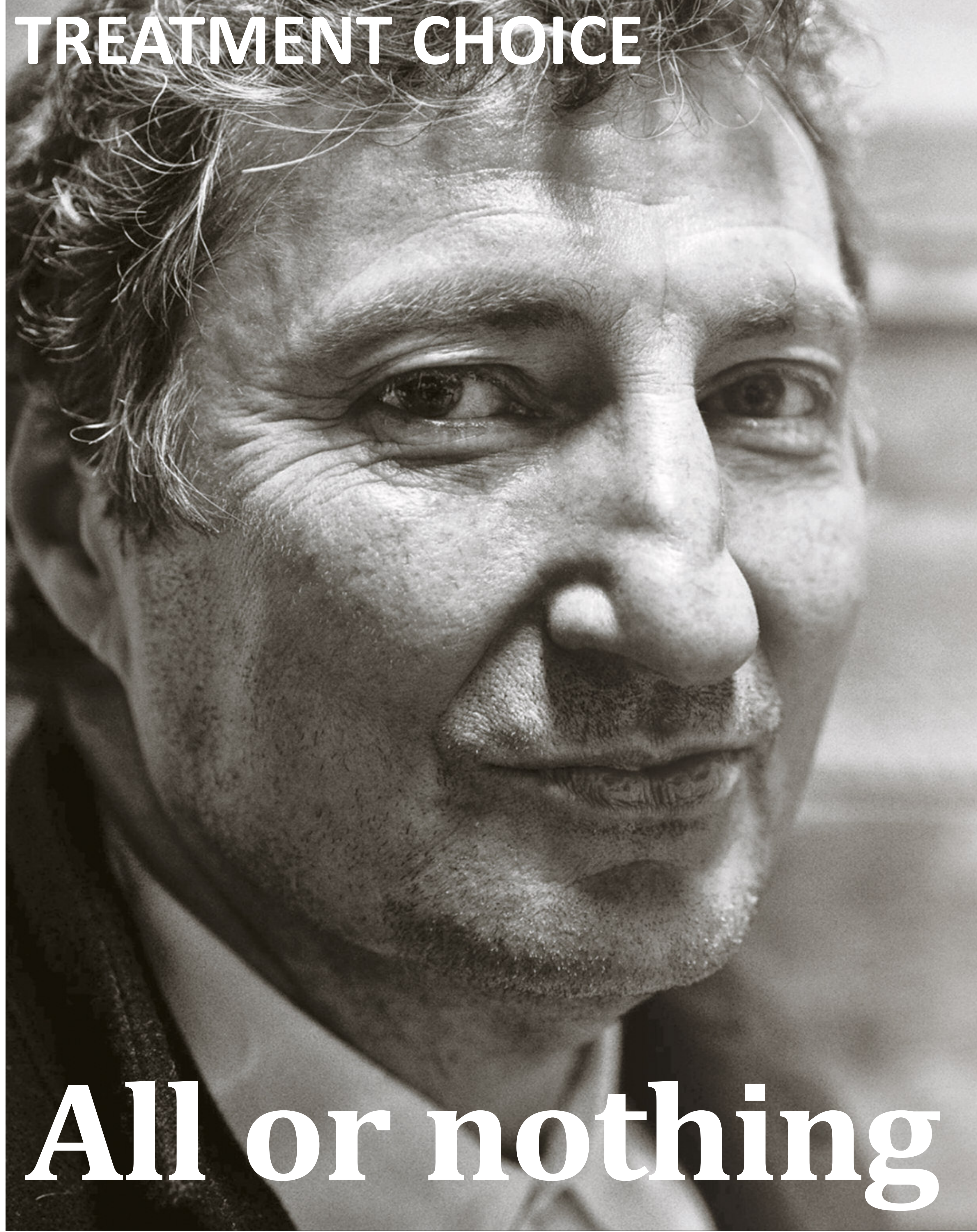
PRESIDENT TRUMP has declared that his administration is getting serious about the opioid epidemic several times since taking office. But he has repeatedly failed to offer a substantive plan – and he has floated at least a few truly absurd ideas. He did it again this week. The president went on at length about his preposterous proposal to fight the scourge of drugs by executing drug dealers – an idea that many experts say would not stand up in court and would do little to end this epidemic... It was Mr Trump playing his greatest 'law and order' hits – as usual, full of sound and fury but signifying nothing.
***New York Times* editorial, 20 March**

IT WOULD BE WRONG TO LEGALISE recreational cannabis use, particularly given the evidence that excessive use can cause mental health problems. But that should not prevent scientists and doctors from developing useful medicines to help people who are suffering.
***Scotsman* editorial, 17 March**

SO LONG AS WE LEAVE decisions on drugs that are both medicines and recreational substances to the Home Office we won't progress, as they seem unable or unwilling to see beyond their failed 'ban everything' strategy.
David Nutt, *Spectator*, 19 March

HEPATITIS C could be the UK's next big public health success story. But if we want to eliminate it by 2025 we need a concerted and coordinated effort to find undiagnosed patients and treat them. This is the biggest obstacle we face so it requires everyone to join forces, from homelessness and drug and alcohol charities to GPs and public health directors, and from sexual health clinicians to prison staff. I welcome the approach that NHS England is taking to identify those living with the virus and our work must be carefully coordinated to ensure no areas lose out. Vulnerable patients should be automatically tested at their GP, while testing should also be readily available at sexual health clinics and pharmacies – and amongst the prison population.
Steve Ryder, *Telegraph*, 20 March

SOME USERS might be more susceptible than others to the trap of addiction, but Ant [McPartlin] and others like him are not in the grip of an uncontrollable disease that is to blame for all their woes. They are not victims, and it doesn't help them to be treated as helpless amoeba at the mercy of their own desire.
This whole concept of addiction as a disease originated in the US not very long ago, where it was classified as such so that people could get it covered by their medical insurance policies. If it was a disease, went the reasoning, then you could get treatment for it, and then you could get that treatment paid for.
However, it is your choice as an adult whether or not you swallow the drink and ingest the drugs that exacerbate your condition.
Jan Moir, *Mail*, 23 March



All or nothing

More on the 12-step debate at www.drinkanddrugsnews.com

The 12-step fellowships are a life-saver for some – but for others, the concept of total surrender can do more harm than good. **Alex Boyt** makes the case from his own experience. Photo by Nigel Brunsdon

I was first arrested for drugs in 1973, did my first three rehabs by 1987, and having been told early on I had a progressive and terminal disease that needed a permanent 12-step solution, I did about 3,000 Narcotics Anonymous meetings over the next 28 years. Though twice in my life it had played a central part in pulling me out of extreme injecting drug use, I was never convinced by the requirement to surrender and admit powerlessness.

The notion that I would always be an addict because I once had a problem felt very limiting to me. The relentless echo chamber of the fellowship however had me trapped, afraid that to question the need for a 12-step remedy would lead me back to jails, institutions and death.

The continuous references to God and prayer had always been an irritant, but what really began to grate on me was the requirement to swallow and regurgitate the 'fact' of suffering from an endless incurable illness that meant eternal vigilance. The sense of belonging was undeniably valuable, but it was conditional on acknowledging the 12-step programme as a God-given gift for which one must be grateful.

Within the 12-step environment you cannot have conversations about healthy ways to disengage, since leaving is the first step to relapse. Stories of people doing well without NA meetings were rarely mentioned and then dismissed as rare exceptions, or otherwise as people who had never really had 'the problem' in the first place.

When I started to work in the addictions field in 2005 however, I began to experience a wider world of addiction and recovery and to discover that endless disease was not seen by all as the optimum route to wellbeing. I came across research papers and data, witnessed the tensions between harm reductionists and abstentionists, and began to build a picture of reality that made more sense to me.

I found support groups for people trying to leave 12-step fellowships, heard of counsellors who specialised in helping de-programme people from the fellowship mindset and I caught up with people I knew from Narcotics Anonymous in the '80s and '90s – many of whom had long given up meetings and were doing fine, abstinent or not.

I embarked on the process of disengaging myself, though the years of exposure to fellowship mantras had me wondering if, somehow, I was being deceived by a mind I had been taught I could not trust. When I met fellowship people, there was often a look of concern in their eyes and I found myself being defensive and feeling a little uneasy... I thank my therapist for supporting me through the transition.

Nonetheless, as I continued my journey it became clearer that the 12-step model, sold to me as the one true route out of addiction – though it suited some – did not hold up so well to closer inspection. Although you can, of course, find numbers and evidence to support any stance, I found the large American NESARC study that showed most people with a drink problem recovered without any intervention (12-step or otherwise) and many without abstinence.

I started to look at success rates which could be measured in different ways; many of the headline numbers put AA success rates at around 10 per cent, though better for those that stuck around longer.

The peer support, collective direction and structure of 12-step fellowships are a perfect combination for some. But it could be argued that for the population as a whole, 12-step intervention is little better than doing nothing. What is clear is the 12-step environment is no magic bullet and that significant amounts – if not more – recovery in its various forms takes place elsewhere.

Another piece of research that resonated with my experience was the Miller *et al* study, showing that when you want to find the main predictor of relapse, belief in the disease model is a significant factor. The 'all or nothing' measure of success and failure within the total abstinence framework is a two-edged sword. If you convince someone that any use is a calamity and that any attempt at self-control is futile, it can be a dangerous combination. A beer on a sunny afternoon will wipe all the clean time and status within the support group and bring the shame of failure bearing down, so there is very little more to be lost in returning to problematic use.

Now someone who has never come across the disease concept would very likely, well, just have a beer. The powerlessness message may help those who are totally abstinent, but is more likely to harm those who are not.

If we throw into the mix people who have been persuaded off their psychiatric meds by well-meaning amateurs in the name of being 'clean', then risks begin to increase. If you function well and are happy with total abstinence of the purest kind, then great, and hats off to you. But it is rarely right to tell someone with a whole personalised set of trauma and resources to follow your path.

Those on methadone may not be 'clean' in some people's eyes, but it is the number one evidenced intervention in reducing drug-related deaths, which are at an all-time high. Those on medications are often being kept safe by them, but all too often are subject to stigma within the 12-step environment, and pressure mounts to stop taking them.

Some say that addiction is an equal opportunities affliction, but that is demonstrably false. The data shows that deprived communities have the highest rates of addiction, and the privileged have better rates of recovery. Too often I hear celebrities extolling the virtues of 12-step recovery – and that is all very well If you are successful, with significant internal and external resources. But telling someone with problematic drug use to get clean can be like telling a homeless beggar to get a job.

Last time I wrote an article discussing the merits of the 12-step environment the letters pages were hot for months, attacking and defending me, and I was reluctant to take the flak again. Nonetheless I write this for two reasons.

Firstly, I say to those for whom it works well: be gentle with others. The chances are that they may well find a way to recover without the fellowships, so go easy on the 'all or nothing' rhetoric. You may mean well, but it does not help everyone.

Secondly, for those who do not feel the fellowship environment is right for them, either initially or after some time, there is nothing wrong with exploring other options. If my son had a problem, the 12-step solution would not be my first choice.

I was thinking about those I know with drug histories who have died too early – either accidentally or who have killed themselves – and you know what? It's the ones who have been told they are powerless and have failed without abstinence that make up the majority who have gone. I don't hold this up as evidence; just an observation from my experience.

The six 12-step rehabs I went through were sometimes a godsend and at other times served only to reinforce my sense of failure. The fellowships have been a great resource for me at critical times, and the weird cult-like structures have been useful to turn things round. But the premise of endless disease has not felt healthy for me in the long run.

I know many people who consider the 12-step model a life saver for which they are very grateful. I know others who used it for a while and then happily moved on. But I also know too many who have felt diminished by their experience.

I will end with a word of caution. A support structure is a big deal; if you leave one, don't do it without putting something else in place. And if you choose a beer on a sunny afternoon after a period of 12-step abstinence, the sense of failure is more likely to do the damage than the thing you consume.

Whatever you choose, I wish you well.

Alex Boyt has worked until recently as a service user coordinator in London and is still actively involved in drug policy debate

MAKING

Commissioners are on a mission to do things better. But how can they take on board the many complex health issues with less money in the pot? DDN reports

DO MORE WITH LESS

There's much talk of developing innovative commissioning practice – prompted, in the main, by the need to 'do more with less'. As part of the refining process, many services are letting go of the specialist posts that would have been central to operations just a few years ago.

In our March issue (page 20) the alliance of NHS providers, NHSSMPA, highlighted the 'significant decline in registered staff, including nurses, social workers, clinical psychologists and doctors' and cautioned that some drug and alcohol services had begun relying on limited clinical expertise.

Through a recent suite of documents for commissioners, providers and clinicians, Public Health England (PHE) emphasised the many and varied roles that specialist doctors, nurses and psychiatrists should play in addiction services. These highly trained professionals are, they reminded us, not just there to provide medical treatment in response to highly complex needs – although those are the elements of their roles that cannot be fulfilled effectively by lesser trained and qualified staff.

PHE named many other skills that enhance quality and leadership within teams, as well as integrating many public health activities and interventions. Furthermore, they pointed out, specialists can help to coordinate resources in a way that adds cost efficiency to a system stretched to breaking point.

MULTI-SKILLED VALUE

The fact that nurses are such 'a multi-skilled breed' is without doubt why they bring such good value to drug and alcohol services, says Ishbel Straker, a clinical director and board member of the nurses' association IntANSA. Their expertise in therapeutic engagement, assessment and care planning, health care delivery, disease prevention and prescribing works alongside their commitment to the NMC standards – 'prioritising people, practising effectively, preserving safety and promoting professionalism and trust'.

'We are ever evolving to meet our clients' needs and the needs of our services,' she says. 'We work with harm minimisation at the forefront of our minds, while giving advice, assessing and treating through a variety of activities such as vaccinations, lung function tests, wound care, blood sugar monitoring, ECGs and sexual health – all of which are measurable outcomes.'

'Looking at the client from the centre of their needs' has become the way of working at Change, Grow, Live, says Dr Arif Rahman, CGL's consultant addiction psychiatrist. Far from dispensing with the psychiatrist's role, CGL have put it right at the centre of their services.

'It's really good for the client as it gives them a specialist assessment that's holistic. We're medically trained, psychiatrically trained and substance misuse trained... The whole ethos is about getting people to the best of their potential,' he says. 'We can identify, support and manage, and if necessary liaise with other specialists around the aspects of clients' needs. For example, I'm in frequent contact with a pain specialist, a liver specialist and secondary mental health services.'

HOLISTIC AGENDA

Many clients find it easier to engage with a substance misuse charity than to access a liver specialist, engage with a mental health team, or ask for testing for blood-borne viruses or screening for respiratory disorders, he explains. So whatever the need, he is in a position to liaise with other specialists to bring care to the client.

He talks about 'a new way of working' – not losing skills, but adapting them to take account of updated Models of Care and the client's journey. He acknowledges that there have been cuts to services and restructuring in a lot of places, but feels positive that a 'difficult few years' have given 'an opportunity for looking at things again'. Psychiatry as a profession is in a good place to contribute to a holistic public health agenda, he states, having several decades

ago experienced and adapted to changes that are now happening in health and social services.

Alongside his client assessments, he feels that one of the most important parts of using his expertise is in finding pathways for clients and linking them to colleagues and partner agencies for their health, psychological and social needs.

CREATIVE COMMISSIONING

Chris Lee, a commissioner in Lancashire and a member of the new Faculty of Commissioning, agrees with the need to 'create robust pathways to make sure the skill set is there across all organisations' – particularly as the treatment system now has so many diverse stakeholders including CCGs, the NHS (and the prison estate), local authorities, Collective Voice and the NHSSMPA.

While 'the front door to treatment has changed' and clients might enter treatment through one of many different routes, the current challenges mean that leading through specialisms is more important than ever, he says. 'The money's going out of the system at 100 miles per hour, but the clinical guidelines have been enhanced. So how do you do that with a population that's got ever-increasing complex needs?'

This, he believes, makes the case for a different and more creative brand of commissioning. 'If I sit down and write a specification for a tender this afternoon that mentions an addiction psychiatrist, your bid will come back with an addiction psychiatrist in there,' he says. 'But you can commission differently. You can say, "you'll be working with people with complex needs, people with co-existing mental health and substance misuse concerns. You'll be dealing with people with long-term homelessness issues, people who are long-term unemployed – and you need to be able to deliver both the clinical and psychosocial model."

'You're not saying that you must have a psychiatrist or a psychologist or whatever – you're saying, "this is the level of complexity you'll be working with; what team would you put out?" It's up to the provider to come back and say what they will give you.'

Lee sees opportunity in the need to mix cost-effectiveness with addressing complex needs, and says 'that's where it gets really exciting, because you can start playing around with different delivery options'.

Traditional ways of working are not 'the given' anymore, right down to the buildings that can constitute one of a service's biggest overheads. The new way of working can be 'light and agile', he suggests – meeting in a coffee shop or a library, using community assets, and freeing up money to spend on staff instead of buildings.

LET'S GET DIGITAL

Service delivery might be able to incorporate digital support – a Skype call, email contact, text support, people filling in their own assessments online, or contact with a keyworker that can be anywhere.

'Even people with highly complex needs could get some of their support through digital means – you could do doctors' appointments by Skype for example to save travelling,' says Lee, adding that there will always need to be a balance between this and traditional face-to-face meetings.

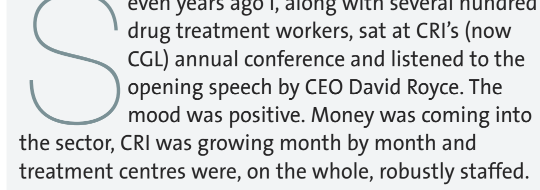
His point is that 'years ago everyone got the same broad-brush approach, but these days you don't do it that way. And if the money's draining out of the system, we can't afford to be working in old-fashioned ways.'

Furthermore, he believes that commissioners have a responsibility to lead on this open-minded approach: 'If the commissioner pretends they know everything, you're robbing yourself of some good ideas,' he says. 'The good providers out there have some really innovative ideas.' **DDN**

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

PATHWAYS

A New Frontier



Seven years ago I, along with several hundred drug treatment workers, sat at CRI's (now CGL) annual conference and listened to the opening speech by CEO David Royce. The mood was positive. Money was coming into the sector, CRI was growing month by month and treatment centres were, on the whole, robustly staffed.

David stood centre stage and whilst enthusiastically praising staff for their continued hard work and commitment, he delivered a stark warning to the room. The future might not be so bright for drug treatment – we must be careful, prepared and fluid. The money that the sector relied upon might not be ring-fenced in the years to come, and we must be ready to change. It might be that treatment needed to branch out and look for money elsewhere. It was likely there would be fewer jobs, and higher caseloads.

Six years later when I was sat in a council meeting listening to the proposed cuts to the treatment budget in York, the reality of the situation finally hit me. Of the four councillors in front of me, one was unashamedly falling asleep. Another, who despite having taken the time to research the subject, asked questions with next to no passion or concern for the excessive reductions in funding. The whole process was a formality, with no press coverage and no real challenge from treatment, all overseen by a powerless commissioner watching the precious budget slip through their hands like sand.

Having left treatment and now working in policy, I have spent a lot of time considering how this situation can be reversed. How can services reach previous levels of funding? What needs to be done to stop the budget cuts? In order to answer these questions the first step is to accept a cold hard truth. The public are not concerned by a reduction in drug treatment budgets. The heroin cohort single-handedly created, funded and sustained treatment for years. From concerns around the spread of blood-borne viruses to drug-related offending, providing treatment with money was not a political hot potato – it simply made sense.

> 'If services around the country looked up from managing the heroin cohort and engaged treatment-naive groups then the money would emerge...'

Years later, heroin deaths are at an all-time high, treatment services have seen record budget cuts and there has been no significant public fallout. While it is easy to blame austerity and government, the truth is that the majority of the PHE budget is happily spent elsewhere – a decision ignored by local communities and the media. As the

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www.drinkanddrugsnews.com

If treatment is to survive it needs to make a more convincing case and reach out to new groups, argues **Paul North**

heroin cohort dies and leaves treatment, so does the money to support them.

The challenge that treatment must confront, and a surefire way of creating funding, is to connect public need with public concern – raising awareness of an issue to attract new referrals, whilst at the same time educating society on the benefits of doing so. This is no small task for treatment and requires innovative outreach. The truth though is that if treatment does not find treatment-naive groups and make a convincing case for supporting them, the government is unlikely to give out funding on the off-chance of success. There needs to be a clear justification for funding, and concern to match it.

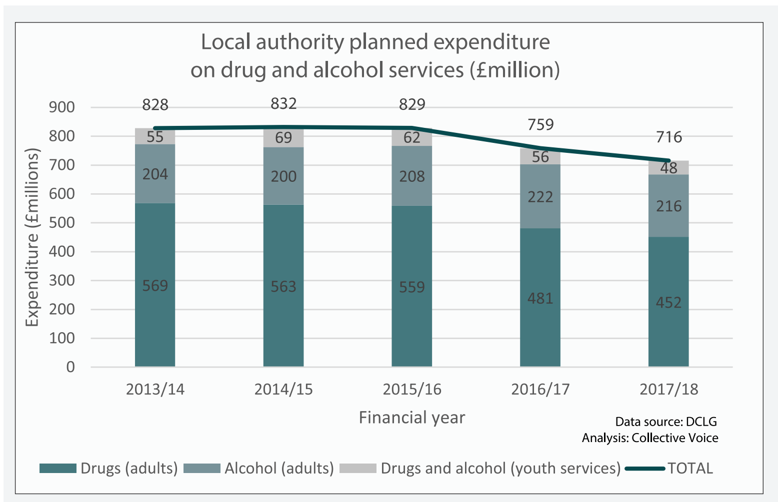
Creating public concern often requires a good narrative, and these narratives must also be backed up by data and evidence. The first step then is to prove the need, by evidencing that there are hundreds of thousands of people who require support. All these people who would benefit so much from treatment need to walk in through the front door – these stats then need to find themselves on the desks of commissioners as well as the local press. At a local level, let people know the great work the treatment service is doing and encourage others to get support. Identify a group and prepare them for treatment, get them on NDTMS and prove treatment still has a use outside of the heroin cohort.

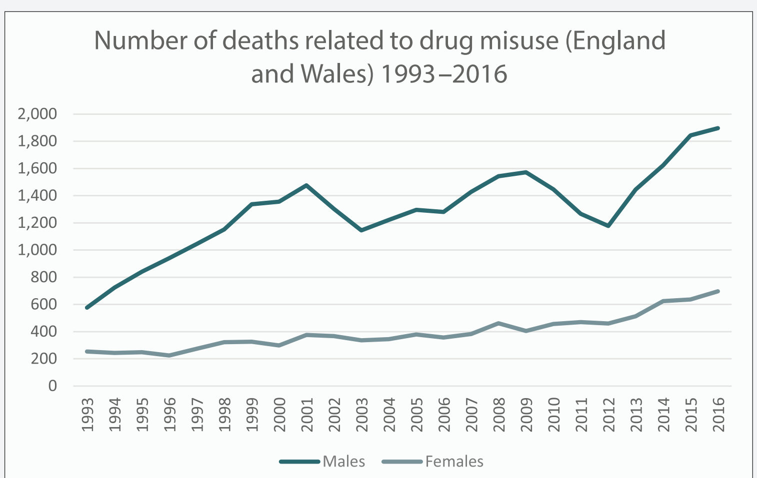
The first group that treatment could target is an easy win. Last year, 23.8m opiate prescriptions were dispensed in the UK. Use of painkillers has risen by 80 per cent in ten years and is costing the NHS billions of pounds – there are no doubt hundreds of thousands of people using opiates problematically on prescription. They are easily accessible, in every community across the UK, and reducing their use would save the NHS millions of pounds. Furthermore such an approach would bring significant health benefits, as it is estimated that up to 90 per cent of prescribed opiates are ineffective at addressing chronic pain. Treatment services are essential if such a reliance is to be reduced – without a planned therapeutic intervention a situation similar to that in the US could emerge where those taken off ineffective prescriptions simply seek out illicit opiates.

It is clear that a very strong economic and health argument could be made for engaging this group. Save money, put some of it into treatment and reduce the vast numbers of people on poorly managed opiate prescriptions.

The next key group is the hundreds of thousands of cannabis users that do not enter treatment. Last year we showed in Liz McCulloch's report Black sheep that cannabis presentations have risen by 55 per cent in ten years. My report *Street lottery* estimated that this equates to 200,000 cannabis users in the UK. Cannabis represents both the fastest growing cohort of drug users, and the most commonly used drug among young people and adults. As outlined in *Black sheep* treatment has not yet made a convincing case for engaging this group as we are ignorant of the health and economic benefits of doing so. This group require bespoke outreach interventions and campaigns to engage. Without any effort at all the group has doubled in size in ten years. Imagine what it would look like if treatment made a more concerted effort.

If services around the country looked up from managing the heroin cohort and engaged treatment-naive groups then the money would emerge – the





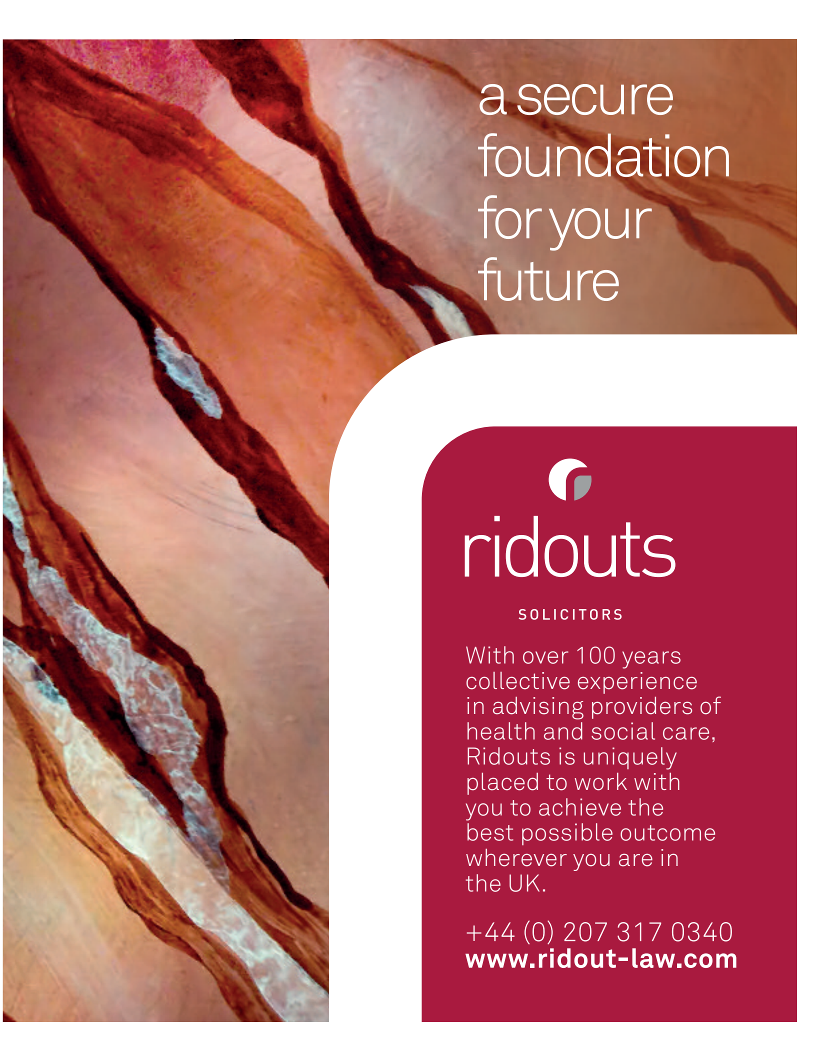
national press would have a story, further educating the public on the changing face of treatment and encouraging others to seek support. The issue of funding services would then likely receive far more public support. Such a strategy would unite public concern with public support, thereby validating funding.

This is not about ditching the important service that treatment provides for the heroin cohort. It is about ensuring in years to come it can continue to do so effectively. Treatment needs to stay well funded and healthy to support heroin users at a time when overdoses are at an all- time high. Those on the frontline of drug treatment know full well the importance of continued support for this group.

This is an exciting proposition for those working in treatment. The chance to explore a new frontier and engage groups who have historically avoided support. A chance to show government the innovation that the sector is capable of and share the life-changing work that has been going on in key-work rooms up and down the UK for years.

To those who are sat with overwhelming caseloads, complex clients and demanding targets, the only way out of that picture is to adapt. The heroin cohort created treatment but if services don't act they might also spell the end of it. They are no doubt a vulnerable and difficult cohort to work with who need bespoke support, but they are not the key to future funding. If treatment does not grasp this opportunity quickly and make a convincing case for more money then it will disappear into irrelevance, and only have itself to blame.

Paul North is head of communications at Volteface, @Paul_North
Graph data from Beyond the tipping point at www.recovery-partnership.org



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