DRINK AND DRUGS NEWS

DDN

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THE FEAR INSIDE

WHY BRITAIN'S PRISONERS ARE TURNING TO HEROIN

Plus: Full round-up from this year's National Needle Exchange Forum

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'It's a mismatch between prison and complex needs'

We need a new dialogue and thinking, says police and crime commissioner David Jamieson, talking about his recommendations to divert people away from the courts and into treatment (page 8). 'Criminalisation of drugs will be looked back on with as much disgust as criminalisation of homosexuality,' adds former detective sergeant Neil Woods, speaking at the same NNEF event.

We have long heard the call to stop wasting money on the drug war from healthcare workers – those at the sharp end of human suffering and misery. But when the pieces of the jigsaw join with those from the criminal justice, policy and treatment sectors, there is surely enough to complete the picture that health must come first – and that it is politicians' duty to take account of the evidence.

The prison population has expanded rapidly and institutions are bursting at the seams. Lana Durjava's study of people who used heroin in prison (page 6) shines a light on the mismatch between incarceration and complex needs. The motivation is to self-medicate, to shut down responses and deaden the pain – summarised as 'a life of lonely compulsion in a mundane and ruthless environment'. If they are lucky enough to receive treatment, they are still vulnerable to leaving prison without the support, the right medication, or even a take-home naloxone kit to keep them alive.

So where does this ineffectual policy leave us? In the meantime, our prisoner is trying to block out each day more than the last.

Claire Brown, editor

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

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ALCOHOL TREATMENT AT CRISIS POINT, SAYS REPORT

A CYCLE OF DISINVESTMENT coupled with reduced capacity and staffing levels means that the alcohol treatment sector in England is in crisis, according to a new report. The situation is putting 'hundreds of thousands of people at risk', says *The hardest hit: addressing the crisis in alcohol treatment services*, which is published by the charity formed from the merger of Alcohol Concern and Alcohol Research UK.

Rapid re-tendering cycles, lack of political support, loss of qualified staff and funding cuts are having a severe impact, the document warns, with the end of ring-fenced public health funding in 2020 likely to worsen the situation further. It is estimated that there are almost 600,000 people in England who are alcohol-dependent and in need of specialist treatment.

The report is based on the views of more than 150 respondents including service providers, GPs, nurses and others, who reported funding cuts of between 10 and 58 per cent. Almost 90 per cent felt that resources in their area were insufficient, with nearly 60 per cent saying the situation had worsened in the last three years. Community detox and residential rehab were felt to be particularly at risk, and more than 60 per cent of respondents stated that appropriate care for people with both an alcohol and mental health problem was unavailable in their area.

The report, which was published on the day minimum pricing was implemented in Scotland, calls on the government to develop and implement a national alcohol strategy, and 'urgently plug the gap' in treatment funding. It also calls for a national review of staffing to identify the levels of expertise needed at each point in the system. While the use of peer mentors was widely welcomed, there was concern that many were being employed 'without sufficient training and for economic reasons rather than to improve provision', the report adds.

'Around 595,000 people in the UK are dependent on alcohol,' said the charity's CEO, Dr Richard Piper. 'It's clear that the government must develop a national alcohol strategy to address the harm they and their families face, and include treatment at its heart to reduce the suffering of the four in every five who currently do not access the services they need. This report shows very clearly what action is needed and we urge policy makers, practitioners and service providers to join together to implement these recommendations to help the hundreds of thousands of people who are in desperate need of support.'

'This report shows very clearly what action is needed...'

DR RICHARD PIPER

Meanwhile, people on higher incomes are more likely to drink regularly, according to statistics from two new reports. Almost 80 per cent of those earning £40,000 or above reported drinking alcohol in the previous week, compared to 58 per cent of all adults. For people earning under £10,000 per year the figure was 47 per cent. The total percentage of adults who reported having consumed alcohol in the previous week was largely unchanged from the previous year but almost 10 per cent lower than a decade ago, say *Adult drinking habits in Great Britain: 2017* and *Statistics on alcohol, England 2018*.

Reports at www.alcoholconcern.org.uk, digital.nhs.uk and www.ons.gov.uk. Link directly through the story on www.drinkanddrugsnews.com

COUNTY COORDINATION

THE GOVERNMENT is to establish a £3.6m National County Lines Coordination Centre as part of its Serious Violence Strategy. The strategy identifies 'the changing drugs market' – in particular, around crack cocaine – as 'a key driver harming our communities'. Last year saw a 23 per cent increase in the numbers of people seeking treatment for crack (*DDN*, December/January, page 5) as well as a two-thirds increase in the number of minors reported to the authorities as potential 'modern slavery' victims – due in part to rising number of 'county lines' gang referrals (*DDN*, April, page 4). 'We need to engage with our young people early and to provide the incentives and credible alternatives that will prevent them from being drawn into crime in the first place,' said former home secretary Amber Rudd. *Document at www.gov.uk/government/publications/serious-violence-strategy*

DARK DAYS

A £9M FUND WILL BE ALLOCATED to tackle the use of the 'dark web' to sell drugs, guns and carry out other illegal activities, the Home Office has announced. The anonymity of dark web spaces 'emboldens people to break the law in the most horrifying of ways with platforms that enable dangerous crimes and appalling abuse', said Amber Rudd. 'You can buy half a kilogram of fentanyl, the drug responsible for over 20,000 overdose deaths in the US in the last year alone, for around £5 a gram.'

DIVERSIONS DOWN

DIVERSIONS OF TOP-STRENGTH 10MG DIAZEPAM TABLETS to the black market potentially fell by more than 60 per cent between 2016 and 2017, according to the Medicines and Healthcare Regulatory Agency (MHRA). Trading of drugs such as nitrazepam, temazepam and zolpidem had also fallen, says the agency, which recently announced a crackdown on the diversion of benzodiazepines and other drugs to the illegal market (*DDN*, February, page 4). 'It is a serious criminal offence to sell medicines outside of the regulated supply chain and the latest figures show our unabated efforts to identify and prosecute criminals are having an effect,' said MHRA head of enforcement Alastair Jeffrey. 'The criminals involved are exploiting people to make money and have no concern about the health and wellbeing of people who buy the medicines.'

HEARING AIDE

AN APP TO HELP PEOPLE ARRESTED FOR DRUG POSSESSION has been launched by Release. Legal Aide was created by the charity's lawyers to educate people on the different 'out of court disposals' available, as well as provide advice on preparing for court, what to say in the hearing and more. 'The cuts to legal aid have left thousands of people unrepresented in cases involving possession of small quantities of drugs,' said head of legal services Kirstie Douse. 'This has created inequality in the criminal justice system whereby those with resources, who can afford to pay for private legal representation, will often receive less punitive penalties compared to those who go unrepresented. We hope that this tool empowers people to engage with the law in order to ensure that it is applied accurately and fairly.'

'Cuts to legal aid have left people unrepresented...'

KIRSTIE DOUSE

App at www.release.org.uk

ROYAL COLLEGE OF PHYSICIANS BACKS DECRIMINALISATION

IN WHAT IS BEING SEEN AS A LANDMARK MOVE, the Royal College of Physicians (RCP) has issued a statement backing drug decriminalisation. After a meeting of its council the RCP has signalled its formal support for the Royal Society of Public Health's *Taking a new line on drugs* report from two years ago (*DDN*, July/August 2016, page 4) and the 'evidence-based recommendations' it advocates.

Among the recommendations were for the personal possession of all illegal drugs to be decriminalised, and for a transfer of responsibility for drug policy from the Home Office to the Department of Health. 'The RCP strongly supports the view that drug addiction must be considered a health issue first and foremost' the statement reads, adding that the organisation had been 'alarmed' by rising rates of drug-related deaths (*DDN*, September 2017, page 4) as well as increasing numbers of drug poisonings and hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioural disorders (*DDN*, March, page 5).

The statistics 'demonstrate a clear need for physical, psychological and social support and care for people addicted to drugs', says RCP, adding that diminishing resources in the field were 'of critical concern'. The royal college 'seeks urgent action to prioritise and increase investment in public health services and workforce in order to meet rising population need' it states. The RCP, which has a membership almost 35,000, is the most high profile medical body so far to back drug law reform.

'We are delighted that the Royal College of Physicians has voted to endorse our position on drug policy reform,' said RSPH chief executive Shirley Cramer. 'That such an influential medical body has put its weight behind a public health and harm reduction approach to drugs, including the decriminalisation of personal possession and use, goes to show just how far the debate on this issue has moved forward – and how far behind the curve many politicians in the UK still are.'

'It is critical that the health community speaks with a united voice...'
SHIRLEY CRAMER

There was now a growing consensus that 'criminal justice approaches' to drug harm had failed, she added. 'It is critical that the health community speaks with a united voice on this issue in order to drive meaningful policy change, and so we hope other medical colleges will soon follow the lead of the RCP.'

RCP statement at www.rcplondon.ac.uk/news/rcp-supports-royal-society-public-health-report-drug-policy

SILO STUDY

The government needs to ensure that its next alcohol and mental health strategies address the needs of people with co-occurring conditions, says a report from the Institute of Alcohol Studies (IAS) and the Centre for Mental Health. The treatment systems for both sectors 'fail to acknowledge each other's existence', says *Alcohol and mental health: policy and practice in England*, with the accessibility and quality of care offered to homeless people a particular concern. While financial constraints on local authorities are a major factor, so is poor communication and lack of trust, the organisations state. 'Our report shines a light on what professionals in both alcohol and mental health service sectors have known for some time – but the problems of joint service provision have rarely been acknowledged outside both fields until now,' said IAS chief executive Katherine Brown.

Report at www.ias.org.uk

'The problems of joint service provision have rarely been acknowledged outside both fields.'
KATHERINE BROWN

RISKY BUSINESS

THE UK'S COMPARATIVELY LOW THRESHOLD for recommended safe drinking levels has been supported by a major study in the *Lancet*. *Risk thresholds for alcohol consumption* studied almost 600,000 people without previous cardiovascular disease across 19 countries, and found the 'minimum mortality risk' to be around, or below, 100g of alcohol per week. Drinking above that level was found to increase the risk of heart failure, stroke, fatal hypertensive disease and fatal aortic aneurysm. While people drinking at the current UK guideline levels would face little increased risk, drinking above two units a day means the 'death rates steadily climb', said Winton professor for the public understanding of risk at Cambridge University, Prof David Spiegelhalter. 'The paper estimates a 40-year-old drinking four units a day above the guidelines has roughly two years lower life expectancy, which is around a twentieth of their remaining life. So it's as if each unit above guidelines is taking, on average, about 15 minutes of life, about the same as a cigarette.' *Study at www.thelancet.com*

PROPER PROTECTION

EDUCATIONAL INSTITUTIONS ARE FAILING to protect their students from the 'potential harms of drugs', according to a report from the NUS and Release. The document is based on a review of institutional support available at more than 150 universities and colleges, as well as a survey of over 2,800 UK students. Forty per cent of students said they would not feel comfortable disclosing information about their drug use because of fear of punishment, while in the 2016-17 academic year there were more than 500 incidents of students being reported to the police for possession. 'We are deeply concerned about the punitive approach taken towards student drug use in some institutions and the appropriateness of support that is offered around drugs in most cases,' said policy researcher at Release, Zoe Carre.

Taking the hit: student drug use and how institutions respond at www.release.org.uk

PARENT PLEDGE

THE GOVERNMENT HAS PLEDGED to increase support for the estimated 200,000 children living with alcohol-dependent parents. The plans include faster identification of at-risk children and early intervention programmes to reduce the number of children taken into care, and are backed by £6m funding from DHSC and DWP. Public health minister Steve Brine has also been named as dedicated minister with specific responsibility for the issue. 'All children deserve to feel safe – and it is a cruel reality that those growing up with alcoholic parents are robbed of this basic need,' he said.

The Fear Inside

A study of people who used heroin in prison gives vital clues on reaching out to this significant and vulnerable cohort. **Lana Durjarva** shares her findings

Recent reports on drug use in prison have highlighted the increased use of new psychoactive substances; however heroin is still a significant concern and tends to be used for longer periods than other drugs such as cocaine and amphetamine. Additionally, prisoners often present with dual diagnosis and polysubstance addiction, which amplify problems associated with their wellbeing and raise concerns for staff and prison security.

Heroin use carries multiple health, legal and social implications, such as increased risk of blood-borne viruses, infections, injecting-related complications, poor health, risk of overdose, social isolation and engagement in criminal activities. In a prison setting it carries additional challenges, with individuals often engaging in riskier behaviour due to contextual factors such as unsafe environment, limited availability of harm reduction services and a climate in which they have to hide their drug use to avoid punishment for failing mandatory drug testing.

Incarceration has an overwhelming impact on everyday life. It brings multiple losses, some of which are irretrievable – loss of liberty, relationships, opportunities, time, and control over one's own life – and heroin use is one of the means of coping with these losses. The prison environment, with its climate of hostility, suspicion and unpredictability, means regular exposure to feelings of isolation and threats of violence.

The prison population in England and Wales has doubled in the last 25 years due to increases in custodial sentencing and sentence lengths. This has resulted in a population comprising many more prisoners with mental health problems, substance use disorders and histories of self-harm and suicide attempts.

'HEROIN MADE ME BULLETPROOF'

A qualitative study was conducted with former prisoners who had experienced heroin addiction while inside. The aim was to gain better understanding of psychological and social aspects of the phenomenon, and to explore how to support people in this situation to achieve recovery most effectively.

Compulsive heroin use is generally the result of a number contributing factors; however all participants in the study said that one of the main purposes of their heroin use was to regulate overwhelming emotions. Heroin use was an attempt at self-regulation and management of difficult emotional states, with the ever-present theme being an attempt to disconnect from reality and achieve a state of numbness.

> *'It kept my emotions stable. Constantly when I was on gear, I'd feel composed, I don't get angry, I don't get upset, I just deal with stuff, I feel pretty much invincible when I am on it...*
>
> *'It's not always easy sitting in prison and thinking who's my missus sleeping with now, who's trying to play dad to my daughter, what does my daughter think of me, who's driving my car... Cos you know you lose everything every time you go to prison. You don't get a chance to sort your stuff out, you just lose everything.'* *(Ben)*

The conceptualisation of heroin use as an emotion regulator and coping mechanism, which people resort to because they have failed to develop adaptive responses to stress and negative emotional states, is not something new. It matches the self-medication hypothesis, which argues that a person who is more sensitive to emotional distress and who has a lower ability to self-regulate is at greater risk of progressing from experimental to dependent drug use as a means to cope. Indeed, the results of this study showed that participants used heroin to self-medicate.

Ability to self-soothe in times of distress is essential for healthy emotional functioning and to prevent the person from becoming emotionally overwhelmed. Being unable to do this is commonly connected with the problem of internalisation – not learning how to regulate emotions from a primary caregiver at an early stage, which would have allowed someone to practise effective self-care. People who are addicted to heroin have often been described as having disturbed global ego function, turning to the drug to self-regulate.

Generally speaking, a person's choice of a particular drug is not accidental and different drugs are chosen to cope with different forms of emotional distress. With its characteristic ability to kill physical and emotional pain, heroin appears to be a magic drug, ideal for coping with the pain and loss associated with imprisonment.

> *'It helped me deal with emotions I guess, I mean it helped me suppress them. It made me feel numb and that was what I needed at the time cos life was overwhelming otherwise. I felt depressed and all, but then I took heroin and did not feel anything at all. I could forget the mess I was in, I mean I lost my kids and all and I didn't really care or feel anything about it when I was on heroin.'* *(Mark)*

'IT'S MY OBSESSION'

This study also aimed to explored participants' relationship with heroin – a relationship that was characterised by obsession and ambivalence and was prioritised above individuals' interpersonal relationships. Participants manifested a strong attachment to the drug, which was experienced as a secure base and safe haven. They perceived it as an attachment figure, gravitated towards it in times of distress and used it as a source of comfort and safety.

> *'...I felt I had no control or power over it and it was running me – my missus once said to me that she had a dream I was having an affair and that affair was with drugs, and that was true. I did not understand that back then but it makes sense today.'* *(Simon)*

This tallies with previous research on attachment and heroin addiction, which argued that due to its neuro-biological properties, the drug was used to compensate for the absence of satisfying relationships. It was previously shown that heroin is chosen to serve specific emotional and social needs; so one possibility is that people who experience problems in forming close and trusting relationships gravitate towards heroin use. Later on, their heroin use can complicate interpersonal relations and so limit their potential for forming trusting relationships.

The findings suggested that heroin use has a significant impact on object relations – the need for contact with others. Relationships were made based on drugs, disproportionate power dynamics emerged between heroin users and suppliers, a climate of mistrust was created, and the participants tended to isolate themselves and maintain distance from any meaningful interpersonal contact. Prisoners with drug problems often oscillated between feelings of empowerment and disempowerment, based on their level of addiction and drug accessibility.

More on prison treatment at www.drinkanddrugsnews.com

'[With the other inmates] it was very basic, there was no friendship or relationship there really, it was just focused on getting and using the drugs, that was as far as it went. You were just talking about what's happening and who has the money and who has the gear and who will score and where to use it and stuff like that.' *(Adam)*

The disparity involved in the power dynamics between heroin users and dealers became particularly evident during withdrawal, when biopsychosocial discomfort induced fear and isolation. Sizeable debts could also build up among prisoners, creating additional complications – often compounded by prisoners' mental health problems. Certainly the participants in this study reported mistrust of both the authorities and other prisoners, where heroin had the dual purpose of being both 'a blessing and a curse'.

'You've gotta deal with people who you're buying it off and they obviously use it as an element of power... Then the obvious violence that goes with it as well, cos things don't always run smoothly... People rob other people, nick their stuff, people don't pay people, so it's kinda like, yeah, looking back I don't know how I had the energy to do it.' *(Ben)*

The study aimed to contribute to the existing knowledge about the psychological and social experience of heroin addiction in prison – an experience that could be summarised as a life of lonely compulsion in a mundane and ruthless environment. While the findings cannot be generalised to the wider prison population, they nevertheless offer a fair indication of the everyday reality of people who experience heroin addiction during incarceration.

British prisons are in a state of perpetual crisis, with endemic drug use, bullying and violence being fundamental parts of daily reality. The prison system currently appears to be mostly about containment and risk management and is characterised by limited resources, staff shortages, lack of meaningful activities and support services that are inadequate in responding to prisoners' needs.

It is hoped that, with time, an holistic approach will be more consistently adopted that addresses the multiple health, social and psychological needs of the prison population, despite all the contextual pressures and factors that hinder recovery from compulsive drug use and offending. Furthermore, it is hoped that the prison service will employ less punitive strategies in the detection and punishment of illicit drug users – and that custodial sentencing will incarcerate violent offenders, rather than those who are vulnerable, with complex needs, and deemed 'petty' criminals.

'It kept my emotions stable. Constantly when I was on gear, I'd feel composed, I don't get angry, I don't get upset, I just deal with stuff.'

Lana Durjava has a background in forensic psychology and works at HMP Pentonville

Photofusion / Alamy

NNEF
National Needle Exchange Forum

The National Needle Exchange Forum focused on some vital harm reduction issues, as **DDN** reports. Photography by Nigel Brunsdon

STRAIGHT TO THE POINT

'A 29-year-old kid dying of sepsis in 2018 in the UK's second city.' This was just one drug-related death of many, said National Needle Exchange Forum chair Philippe Bonnet, and reinforced why the focus on harm reduction must not waver and why the work of the NNEF was more vital than ever.

Back after a break in holding its annual event, the NNEF presented a packed conference programme that brought together speakers from health, criminal justice, drug treatment, legal services and policy.

With the first UK drug consumption rooms feeling like a distinct possibility and ever more influential voices and organisations joining the call for decriminalisation, the issues on the programme were bringing back an essential focus on harm reduction.

First speaker to the platform was West Midlands police and crime commissioner David Jamieson, who recently spoke out on the need for treatment over punishment (*DDN*, April, page 6).

'We've got to move away from a polarised binary position – soft or hard on drugs,' he said. 'We need new dialogue and thinking.' Was spending £1.4bn a year in the West Midlands on the 'war on drugs' a good use of resources, he asked. Jamieson had launched a strategy to divert people away from the courts and into treatment, through a series of recommendations that recognised drug dependence as a health issue over a criminal justice one.

As a former detective sergeant and undercover drugs operative, Neil Woods had developed an informed perspective of policing the illicit drug market. 'Locking up nasty people' was a 'constant narrative for the public and press', he said, but the market was so huge that this had a 'tiny impact' and 'the process of policing drugs makes drug dealers more violent'. The growth of 'county lines' was involving children in gangs and causing more violence.

His experience had made him evaluate how police operations increased problems for many vulnerable people in society and conclude that the answer was harm reduction.

'It's the time to be drastic, the time to be brave,' he said. 'Criminalisation of drugs will be looked back on with as much disgust as criminalisation of homosexuality.'

Public Health England's drugs and alcohol manager, Tony Mercer, had been asked to comment on the arguments of harm reduction versus abstinence – a 'polarised debate' that worried him.

'Ideology can get in the way of interventions,' he said. 'We need workers who are happy to provide whatever's needed at the time.' Spending energy on a debate that couldn't be solved meant taking our eye off the ball, he added. 'It's a debate that can't be resolved, so we need to reframe it.'

Referring to William White's work on the need for different interventions, he said 'The aim of everything should be to reach and engage people.'

Effective engagement was a central theme for all of the speakers, with the prospect of the first UK drug consumption rooms. They would be a unique part of engaging people, though not a panacea, according to the Scottish Drugs Forum's Kirsten Horsburgh. 'We need a whole range of different things,' she said. Looking at the situation in her Glasgow neighbourhood demonstrated very clearly the difference they would make.

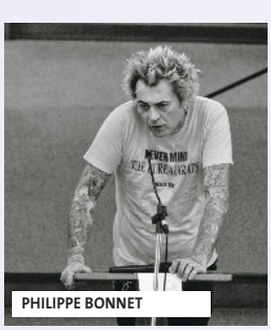
'You don't have to go very far from the main shopping areas to find needle litter and discarded injecting equipment,' she said. 'We're already providing sterile injecting equipment but not the rooms to use in.' People needed to inject in public places – back alleys, toilets, or on the streets. In many cases they would be thrown out of hostels if they were caught injecting on the premises.

The constraints on where people could inject made them do it hurriedly – and the need for speed left them vulnerable to violence, stigma, and dangerous injecting practice, said Dr Magdalena Harris, associate professor at the London School of Hygiene and Tropical Medicine.

Urgent injecting led to venous damage and could easily transition to the groin as this was 'quicker and easier in a low light'. She shared the experiences of two people involved in her research: Emma had told her about her transition to skin popping (injecting under the skin), which intensified the harms by causing infection. Gary had described injecting while blood was pouring out of his groin – and had seen this as the only viable option to being misunderstood and mistreated at hospital.

Safe injecting spaces would be 'a place for opportunistic care', said Harris – a place for food, healthcare, and a shared space for other support services such as benefits and housing. The facilities also made sound financial sense, as people were being hospitalised for preventable conditions such as sepsis and gangrene and not seeking treatment early enough.

'Soft tissue infections exacerbate social exclusion,' she added. 'They give problems with mobility and have a massive impact on people's lives.'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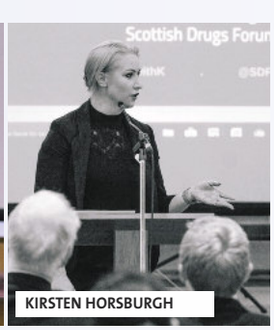


KIRSTEN HORSBURGH


NEIL WOODS


TONY MERCER


MAGDALENA HARRIS

More conference pictures at: www.drinkanddrugsnews.com

Getting the psychological approach right was equally important to tackling exclusion, and Roger Nuttall gave insight from his role as nurse coordinator at Hastings Homeless Service.

He talked about Paul, a 42-year-old man who had gone to his GP surgery with a wound from 'skin popping'. He had disengaged too early from treatment, but since starting to attend the homeless service he had never missed an appointment.

So what had worked in engaging him? The holistic approach to building trust, using counselling skills, respect and empathy, was just as important as the wound care, said Nuttall. 'Homelessness and addiction tend to rob people of their identity. By listening to their background and history you can help them rediscover who they are.'

> 'The aim of everything should be to reach and engage people.'
>
> TONY MERCER

Healthcare environments were often stressful, and raised stress levels (shown through levels of cortisol) had been shown to slow wound healing and impair immunity, he explained. So a little empathy and humility could go a long way in creating the right setting for the transition into treatment.

Another dynamic environment for interaction was the pharmacy, and Kevin Ratcliffe, CGL's non-medical prescribing lead gave insight into initiatives in Birmingham. Needle and syringe programmes (NSP) were being run out of 88 pharmacies in the city, many with extended hours. Service users were actively involved in providing feedback on the quality of services and a mystery shopper exercise had identified things that the community pharmacies could be doing much better – including harm reduction advice.

The exercise also identified a weak link in the chain of Birmingham's take-home naloxone programme – that clients had to be already engaged with a drug treatment service to receive kits. After a pilot phase ('and a lot of learning!') the kits were given out through pharmacies, 'reaching people that services weren't'.

The other valuable role of NSP-commissioned pharmacies was to refer people directly into treatment, and Ratcliffe announced that funding had been secured for hepatitis C testing in the Birmingham pharmacies, with results given within the hour. 'In the city centre we want to get as many people through as possible and refer them into treatment there and then,' he said.

Dr Ahmed Elsharkawy, consultant hepatologist at the Queen Elizabeth Hospital in Birmingham, said that community treatment was critical to NHS England's target of eliminating hepatitis C by 2025. There were no patients now waiting in Birmingham and 'we're running out of people to treat', he said. But the UK needed to be far more proactive in finding people with hep C as there were still more people becoming infected than being cured.

NHS England now needed 'to put their money where their mouth is and stop the rhetoric' on eliminating hep C, he said – particularly as the highly effective new oral treatments represented a cure within eight weeks.

While the route map for hep C seemed clear, it was as important as ever for workers to stay informed of the latest drug trends. CGL's medical director, Dr Prun Bijral, explained some important (yet still widely misunderstood) risks of fentanyl – that potency varied widely, leading to uncertainty around consistency and dosing. When pressed with a bulking agent, 'hotspots' could occur, with pills containing dangerous levels of this potent painkiller.

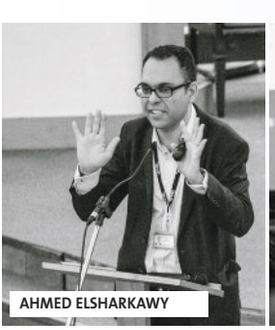
Improving access to medically assisted treatment (MAT) was vital to keeping people safe, in accordance with the Orange Guidelines, he said. The other essential strand of overdose prevention was giving out take-home naloxone kits, as 'the whole community is at risk, not just those in treatment'.

Dr Loretta Ford of the West Midlands Toxicology Laboratory added to the discussion of changing drug trends and explained that toxicology services had to constantly rise to the challenge of detecting new compounds. The 'classic' drugs of misuse had been joined by rising trends in NPS, prescription medication (notably pregabalin and gabapentin), steroids, and over-the-counter meds such as anti-histamines – drugs that had opened up a whole new world of varying potency and uncertainty for the user.

This uncertainty meant that the take-home naloxone programme had an invaluable place in reducing drug-related deaths. Zoe Carre, policy researcher at Release, said that while there had been a significant increase in areas providing naloxone, it was shocking that some local authorities were commissioning drug services without monitoring whether it was being distributed.

Coverage of kits was still not wide enough, and was not reaching the people who needed it. In many areas they were not provided to NSP clients, OST patients or to family, friends and carers of people considered to be at risk. Needless barriers included people having to be assessed or referred before getting a kit, or having to wait for training when the kit contained detailed instructions.

'We recommend that England implements a take-home naloxone programme as a matter of urgency,' she said, and Release was setting up a steering group to develop national guidelines to improve coverage and remove barriers. 'All local authorities should be providing take-home naloxone and every person who uses


AHMED ELSHARKAWY


ZOE CARRE


LORETTA FORD


ROGER NUTTALL


PRUN BIJRAL


KEVIN RATCLIFFE

NNEF CONFERENCE

NNEF
National Needle Exchange Forum

'DCRs don't have to be posh expensive places – just a roof and a kettle.'

DR JUDITH YATES

opiates should be given at least one kit.'

'Naloxone is only part of the solution, but a vital part of the puzzle,' she added. 'There needs to be adequate access to harm reduction advice and information.'

At the end of a full and informative day, it was Dr Judith Yates' job to spell out 'how to reduce harm and save money'. The clearest message was that 'we should be ending the war on people who use drugs,' she said. Decriminalisation was the only model that made sense, 'and we should do this first'.

Secondly, the harm reduction measures that the conference had considered were highly cost effective: 'DCRs don't have to be posh expensive places – just a roof and a kettle,' she said.

The take-home naloxone programme was proving to be extremely effective and was only challenged by stigma and ignorance: 'There isn't another drug that can save a life for £15 in a few minutes,' she said.

Her work in recording drug-related deaths reinforced time and again that these deaths were preventable and showed that 78 per cent of people were not in treatment at the time of death.

'There is huge scope for getting these people in treatment,' she said, calling for an end to re-commissioning and funding cuts. 'Stop wasting money on the drug war and stop treating people who use drugs as criminals.' **DDN**

'I wish I could have bought an idiot's guide to setting up a DCR.'

KASEY ELMORE

Kasey Elmore visited the conference from Australia to share learning points from developing and building Australia's second drug consumption room.

'I wanted to design the best DCR in the world, with no risk. But lesson number one is to accept that this isn't possible,' she said. You had to acknowledge that the service that you want to run, and others in the sector want you to run – your clients, the government, the wider community – all look incredibly different.

'Our model had to be located at our workplace and be medically supervised – an integrated model with nurses, doctors and registered drug and alcohol workers,' she explained. 'It's in a residential area, located on a large public housing estate, and runs a needle and syringe programme giving out 90,000 syringes a month.'

Consulting with the client group was essential, but she felt there wasn't enough time to do it properly. As they designed the layout of facilities, they came up with a three-stage model with zones for registration, injecting and aftercare, which seemed logical but already posed a problem – that people had to inject to get access to the aftercare services. So it became necessary to discuss a stage four, where people could access mental health services etc, if they didn't inject.

There were also some conditions imposed by their licence that they had to adhere to, such as not allowing pregnant women or under-18s to use the facility.

An important part of design was to get the toilets right, with needle disposal, and their location in zones three and four. Would pets be allowed in a health facility, and could a dog get in the way of medical staff? Should there be secure pet parking on site so they were not stolen?

Liaising with key stakeholders on the project meant working with people who had never worked with this client group, so 'pick your battles and build an external consultancy team', Elmore advised, adding 'we're lucky we have an awesome police liaison officer'.

Clients were keen to know the 'house rules', such as the amount of drugs they could take in, and it was important to work out the protocol for supervision, the amount of people allowed in a booth, how to prevent people from stealing each other's drugs, how to stop someone from operating a vehicle afterwards – and would staff be able to inject out of their working hours?

Do not underestimate the time and money needed for staffing, she advised. Finding the right people could be a 'nightmare' and 'training costs a fortune', but it was important to build a team that reacted in the right way to witnessing injecting and responding to an overdose, and weren't bothered by a backlash from residents or the media.

The law in the UK was used as an excuse but there was no real barrier to DCRs, Release's head of legal services **Kirstie Douse** told the conference.

Home Office statements on DCRs ignored public health elements, such as reducing blood-borne viruses and getting people into treatment, and focused on points of the law, such as possession being an offence.

'But is this really insurmountable?' she asked. The legal issues cited related to offences under the Misuse of Drugs Act 1971, other related criminal offences, and civil legal issues. However, she said, 'there are things we're already doing in relation to NSPs that we can do in relation to DCRs.' The focus of the initiative would be on preventing crime and limiting harm.

'Let's step back, take a breath and not get bogged down in the law, but remember that drug-related deaths are the highest since records began,' she said. 'These are not just statistics but real people, and we want to save lives.

'It's up to local areas to take a stand. The law is not as significant an obstacle as people would like you to believe.'

Innovating for EXCELLENCE

The Expert Faculty on Commissioning is an independent group open to commissioners of drug treatment services and others involved in OUD care.

PROGRESS IN THE TREATMENT OF OPIOID USE DISORDER (OUD) has been significant – with innovative developments helping to build a treatment service that has saved many lives – and commissioners in local authority public health departments have an important role in continuing service development for the future.

The Expert Faculty on Commissioning (*DDN*, February, page 10) aims to support commissioners by sharing experience and insights on best practice, with the overall goal of improving outcomes. It is an independent group open to commissioners of drug treatment services and others involved in OUD care, and now presents a congress focussing on commissioning to be held on 22 June at the University of Manchester.

This event, *Excellence in Commissioning for OUD*, will include plenary sessions with some of England's leading experts in OUD care and will be attended by commissioners and others working in this field.

The expert faculty operates on an independent basis, funding work on a project basis with resources from all types of organisation and business. All sources of funding are stated clearly in the context of each project, and those providing resources do not influence the thinking or work of the faculty. Camurus has provided funds for the set up and logistics of this event but has no influence on the set up or content of the meeting, which is independent.

This event is an opportunity to join more than 50 leading experts in OUD care, including commissioners from across the country.

Everyone interested in the future of innovation in OUD care and the evolving role of commissioning is strongly recommended to join this event. Registration is free for those working in the field.

For more information, or to register, visit www.expertfaculty.org/exco

EXCO
EXcellence in Commissioning for Opioid use disorder services
Manchester, 22 June 2018

CONFIRMED SPEAKERS

ROSANNA O'CONNOR (director of alcohol, drugs and tobacco, Public Health England)

PROF ROD THOMSON (director of public health, Shropshire)

MARK MOODY (chief executive, Change, Grow, Live)

MARK GILMAN (Discovering Health)

TERRY PEARSON (drugs and alcohol commissioning manager, Northamptonshire)

NIAMH CULLEN (drug and alcohol programme manager, Calderdale)

CHRIS LEE (public health specialist, substance misuse and tobacco, Lancashire)

PAUL MUSGRAVE (senior manager, public health, Cumbria County Council)

CLIVE HALLAM (substance misuse commissioning manager, Wandsworth and Richmond)

JAYNE RANDALL (drugs and alcohol strategic commissioner, Shropshire)

DÉJÀ VU

While numbers of crack users may be on the increase, the basics of providing an effective service for them haven't changed, says **Danny Hames**

I READ THE SERIOUS VIOLENCE STRATEGY recently produced by the Home Office (see news, page 4) with great interest. Leaving aside the debates in the media regarding police numbers and budgets, I was drawn to the growing concern regarding the increasing prevalence and purity of crack cocaine in UK markets, and its link to increasing levels of serious violence.

The report indicates that the East of England has seen an 18 per cent increase in the estimated number of users of opiates and/or crack cocaine, alongside a 21 per cent increase in the estimated number of crack cocaine users in the South East. Anecdotally, our operational colleagues in the East of England area are noticing a steady increase. As a practitioner in the noughties, both in London and Southampton, I saw the prevalence and damage caused by crack and it prompted me to reflect on what ensures a drug and alcohol treatment service meets the needs of these service users.

As NHS providers we have been at the forefront of operating services for those using crack cocaine and cocaine for many years, both in our drug and alcohol services but also alongside colleagues in mental and physical healthcare services and those in primary care. It seemed relevant at this point that we outline what NHSSMPA believes is good, solid practice when ensuring that we provide strong, effective and relevant services for crack cocaine users. Here are our five get-the-basics-right principles:

1. **MAKE SURE YOUR SERVICE IS ACCESSIBLE**. When a crack cocaine user presents, really take the opportunity to engage and start building a relationship, as the window of opportunity will be small.
2. **HAVE STRONG CASE MANAGEMENT** which is clearly shared and communicated with service users and steadily transitions responsibility for the plan from practitioner to service user. Provide stability and direction amidst the chaos.
3. **ENSURE THAT YOUR STAFF, VOLUNTEERS AND PEER MENTORS ARE WELL TRAINED** and supported to understand the impact of crack cocaine. This will help them to build a relationship with the service user.
4. **ENSURE YOUR RISK MANAGEMENT IS ROBUST**. It needs to be protective to all and also ensure that interventions can be provided effectively – quality psychosocial interventions in the right dose at the right time are vitally important. Close working with psychiatry and psychology is invaluable.
5. **BUILD STRONG LOCAL RELATIONSHIPS** to ensure there is a broad range of recovery interventions available to those affected – both service users and their families.

Danny Hames is chair of the NHS Substance Misuse Providers Alliance (NHSSMPA)

If you would like to know more about NHSSMPA visit www.nhs-substance-misuse-provider-alliance.org.uk or follow them on twitter @NHS_SMPA

Access for autism

Are alcohol services meeting the needs of adults with autism? Alcohol Concern and the University of Bath are working to improve support for this client group and want to hear the views of practitioners, as **Andrew Misell** explains

There are around 700,000 people in the UK on the autistic spectrum – around 1 per cent of the population. When you're on the spectrum, social interaction and communication – with all their unwritten rules and conventions – can be tricky. Reading the thoughts, feelings and behaviours of others can be a minefield. When you're unusually sensitive to sounds, touch, and light, our world of constant stimuli and chatter can be a challenge. And when you add it all up, everyday situations can feel overwhelming.

In the face of all this, retreat into safer spaces and activities is attractive. Indeed, many people with autism do respond to the busyness and bother of the world by avoiding risky or unpredictable situations. This has led in turn to something of an assumption that they are unlikely to misuse alcohol. The logic goes something like this: if someone likes to be clear about where they stand, why start using a substance that makes everything foggier?

'Many people with autism do respond to the busyness and bother of the world by avoiding risky or unpredictable situations. This has led in turn to something of an assumption that they are unlikely to misuse alcohol.'

Initial research by Alcohol Concern, however, suggests that this assumption doesn't match the reality of many autistic people's lives. Although solid evidence is thin on the ground, a recent review by the charity of the current literature – as well as consultations with academics and practitioners – has highlighted a number of issues that alcohol services may need to address, as well as the need for more thorough research into the topic.

Alcohol Concern's investigation has revealed that although people on the autistic spectrum do not appear, necessarily, to drink more than anyone else, that's not the whole story. As with many other stressful conditions, there is evidence that some people with autism self-medicate with alcohol. There is a growing genre of 'autism autobiographies' and several of these have included accounts of the use of alcohol as a stress-management tool. Alcohol use has been found by some to be a successful autism coping strategy in the short-term, enabling them to manage or conceal autism-related difficulties for years – until the alcohol use starts bringing on its own problems.

If people with autism do drink (because of their autism, or for any other reason) there is some evidence that they are likely to have greater difficulty managing their drinking behaviour, and be more prone towards harmful drinking and alcohol dependence. Further problems seem to be encountered at the point at which someone with autism is in need of support to manage their drinking.

The obvious initial obstacle is whether that person feels able to enter the treatment system. Substance misuse treatment centres can be quite chaotic environments, with a fairly constant flow of clients and their companions, some of whom may be disruptive and noisy. Even if a client with autism succeeds in making and attending an appointment, some alcohol treatment approaches – such as those relying on analogies, abstract thinking, or a sense of social self – are likely to be unsuitable for them. The need to be understood is often quite deep in people with autism, and if it becomes clear early on that a practitioner does not properly understand autism, the therapeutic relationship may stop before it starts.

Following from this initial research, Alcohol Concern is now working with the Centre for Applied Autism Research (CAAR) at the University of Bath to explore whether people with autism do access (or seek to access) alcohol treatment services; what happens when they do; and how alcohol services could be made more autism-friendly.

The ultimate aim is to work with services to make the necessary adjustments to promote equality of access for people with autism to alcohol support when they need it. Indeed, one of the most positive things that has already come out of this project is the idea that it may be possible for services to adapt their approaches to play to the strengths of autistic clients, i.e. to engage with them in ways that make the most of their traits.

As part of the project, Alcohol Concern and the research team at Bath are inviting anyone working in substance misuse services to complete a short questionnaire. Whatever your experiences have been – even if you're not sure whether you've encountered clients with autism or how you'd recognise the condition – they'd like to hear your views. The questionnaire shouldn't take more than 15 minutes to complete, and is on the Alcohol Concern website: www.alcoholconcern.org.uk/autism

All information you provide will be anonymous, confidential and securely stored.

Contact: Andrew Misell at Alcohol Concern amisell@alcoholconcern.org.uk, and/or Prof Marl Brosnan at the University of Bath's Centre for Applied Autism Research (CAAR) M.J.Brosnan@bath.ac.uk

MATT'S STORY

For many people whose autism is undiagnosed, alcohol can act as a successful coping strategy – until the alcohol becomes a problem in itself. **Matt Tinsley** shares his story

'The chief aspect of my autism which resulted in extremely heavy use of alcohol to cope was a near constant sense of anxiety. I also was socially awkward and discovered alcohol turned me into a much more relaxed person. Of course, I was unaware of my autism at the time and it's only in retrospect that I can understand why it worked so well.'

Alcohol also helped Matt to function in the workplace and develop and maintain relationships. It meant he was less affected by sensory stressors and so helped manage his anxiety.

'Sensory problems which I have now such as loud noises and certain textured clothes being very uncomfortable were numbed to a certain extent by drink. Being overwhelmed with information when being given instructions was also not a problem when drinking, as I felt able to retain the information. This may sound like the opposite to the way alcohol would affect NTs [neurologically typical – people not on the autism spectrum], but I think that is the key to its success for me, until it became life-threatening – it made me feel and act in a much more neurotypical way.

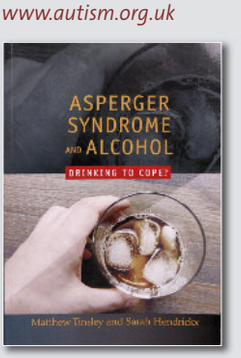
'Alcohol enabled me to do jobs where anxiety might have been crippling – working in an environment with constant contact with the public. Instead, despite being technically drunk, I was very efficient at my jobs and was able to cope doing such jobs for 17 years.'

However the point comes when the level of alcohol required for functioning becomes unsustainable and serious health issues occur. For Matt, that was severe liver damage, collapse and certain death if he continued to drink.

Some services have a requirement that clients be 'dry' before they are accepted for treatment. However for some – possibly undiagnosed – autistic people, for whom alcohol may be their coping strategy against extreme anxiety, it may be the case that they cannot access support as the removal of the alcohol may make them incapable of leaving the house. More awareness of the potential of autism to result in problem drinking is needed in alcohol support services, and there also needs to be recognition of what to look out for.

'The signs to look for that a person with an alcohol problem might also be autistic could be unusual eye-contact, special interests (is there a certain level of 'nerdiness' in what interests the drinker, or do they have one subject at which they are expert at?). Is their use of language (grammar and syntax) unusual in any way, does their conversation sound odd or pedantic? Also, they may just present themselves, as I did, with the conviction that they are autistic and have just discovered why they are like they are. This should definitely be paid attention to, and not dismissed.'

For support on all aspects of living with autism visit www.autism.org.uk



Asperger Syndrome and Alcohol: Drinking to Cope?
By Matthew Tinsley and Sarah Hendrickx, published by Jessica Kingsley Publishers.

LETTERS AND COMMENT

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.


TREATMENT CHOICE

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

All or nothing

'Imagine someone's state of mind who perhaps through hard struggle has abstained from crack and heroin when on a methadone script and then seeks support at NA only to be made to feel unwelcome.'

CAUTIONARY CAVEAT

I was impressed by Alex Boyt's thoughtful and intelligent article regarding 12-step programmes (*DDN*, April, page 12). I wanted to explore the current wisdom of encouraging people who approach drug services struggling with addiction to attend 12-step meetings.

It may be that my experience is particularly shaped by the culture in Bristol where there are an awful lot of people, predominantly men, who have to attend meetings as a condition of living in a 'dry house'. Anyway, unless you are an attractive woman going to a meeting currently using, if you don't have any friends in the fellowship will get you treated like a leper. Imagine someone's state of mind who perhaps through hard struggle has abstained from crack and heroin when on a methadone script and then seeks support at NA only to be made to feel unwelcome. Workers should bear this in mind before encouraging clients to attend.

Some sort of pre-briefing of the rituals at these meetings (hand holding and chanting) would also be wise, as it can seem pretty weird to a newcomer. I'm including these thoughts as notes of caution as I have friends who have gone on to live drug-free lives after using 12-step support.

Richie, Bristol, by email

WHATEVER WORKS

Brilliant read. I did 12-step abstinence for six years, but never felt I was being true to myself and witnessed so much judgement within fellowships. It's 14 years in July since I took my last methadone or any other class A, following nearly 18 years of chaotic addiction and lifestyle. The six-year abstinence was definitely a good foundation for my recovery but once I realised I had a great support network within my life outside of NA I made a choice to get on with my life. So for eight years now I've not questioned myself – if I want a drink with friends I have one. I even went to Amsterdam on a girly trip and had a puff on a joint, didn't beat myself up, no one judged me and guess what... I'm still living and loving a productive life!

I thank the 12 steps for giving me some great principles to apply within my life but I too disagree with the 'powerless forever' statement! If 12 steps forever are what works for you then I'm happy for you, but for me it was the bridge to normal living and the biggest factor in my recovery is definitely my support, acceptance, love and laughter from friends and family. Do what works for you but don't beat yourself up if things don't always go to plan, especially if it's someone else's plan!

Tara, via www.drinkanddrugsnews.com

TO THINE OWN SELF BE TRUE

What am amazing well-written paper. You have raised some valuable points, that I for one have just been discussing with a friend. I am a person in long-term recovery, and have been working on myself for many years. I have always believed that those who commit suicide or relapse either cannot maintain the 'all or nothing' concept or the self-development which I believe is needed to continue in recovery.

I stopped attending the rooms because I changed, as simple as that. I didn't pick up nor do I want to pick up, even after losing a son and more recently the death of my mother. I didn't want to use because I knew that would not be the answer – I do believe that NA is not the answer to everyone's drug problems. I believe we all have a unique guidance system and our soul knows the way. I have worked in drug and alcohol serves and I am now a qualified, integrative therapist in my final month of a BA honours degree. I have wonderful choices now, that I would not change for anyone. Thank you for your article – being my true authentic self has always been my goal.

Anonymous, via www.drinkanddrugsnews.com

RUINOUS READING

Reading this has ruined my day and I was upset it had been even brought anywhere near me. I think you are a clever person who could help a lot of people change – why bother to get bogged down with an unnecessary debate?

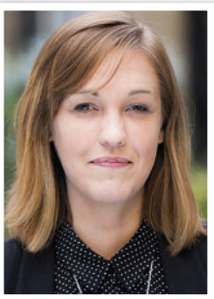
Ellie, via www.drinkanddrugsnews.com

GET SMART

It didn't/doesn't work for me personally. Things didn't really click for me until I found Smart Recovery. That's not to say I didn't find a lot of value in some of the 12 steps approach, I just couldn't get totally comfortable with it – for many reasons. At the end of the day though, it's whatever works for you. Any positive steps.

Craig Rees, via Facebook

LEGAL LINE



Nicole Ridgwell answers your legal questions

'WILL CQC CATCH US OUT?'

With the proposed move by CQC to short-notice inspections coming into force this month, how much leniency will be allowed for one-off issues?

CQC's intention to begin short-notice or unannounced inspections of substance misuse service providers will be a significant change for the sector, which has previously had notice of inspectors' visits and been able to prepare.

It comes at a time when the sector is acutely aware that CQC is watching. In the November 2017 briefing *'Substance misuse services: The quality and safety of residential detoxification'*, CQC set out its significant concerns from the first inspection cycle under the new regime. The headline summary was that CQC took action to require 72 per cent of providers to make improvements due to breaching regulations and failing to meet fundamental standards of care.

'Providers should demand that CQC exercise reasonableness and proportionality.'

Inspections are crucial to CQC's understanding of the services it regulates. The less notice they provide, the less time providers have to prepare. This will understandably cause some nervousness and it may be tempting to request leniency during the period of adaptation.

Unfortunately, however, any such requests are likely to fall on deaf ears for two main reasons.

Firstly, short-notice and unannounced inspections have become increasingly common throughout the regulated sectors in the past few years. CQC gave no leniency to, for example, GP surgeries and dental practices when they introduced unannounced inspections and will feel no need to act differently with this sector.

Secondly, inspections are intended to capture an 'on the day' assessment of a service. Inspectors understand that the more notice given to prepare, the less likely that what they see is identical to normal practice. Short-notice inspections reduce the opportunities available to providers to 'improve' their service, and what the inspectors see is more likely to accurately reflect its normal running.

To expect inspectors to be more lenient because the provider does not have this extra notice period will be met with a less than positive response. That said, the rules of challenging the resulting draft inspection reports remain the same and it is just as important to challenge that which is not factually accurate.

We regularly view draft inspection reports which use isolated or one-off issues to improperly extrapolate a conclusion of systemic failure. This presents a false assessment of the service, and must be challenged through evidence that shows that a one-off issue is not representative of the wider service.

In summary, providers should not be asking for 'leniency', but should instead be demanding that CQC exercise reasonableness and proportionality when assessing those one-off issues. To do otherwise would be to publish a misleading report – something which is of no benefit to the public, the service or the reputation of the regulator.

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

MEDIA SAVVY

The news, and the skews, in the national media

OBVIOUSLY, IT'S FAR MORE HARMFUL TO DRINK HEAVILY. However, the part of the [*Lancet*] study relating to moderate drinking appears to be mainly middle-class territory – the 'one (or two) glasses of red a night won't do me any harm and probably quite a bit of good' self-delusion desperados, who seem to think their alcohol can't hurt them because they bought it from Waitrose... It could be a pricey bottle or a dented can from the budget bin of the supermarket, but drink too much of it, at the right strength, and it will affect your health.
Barbara Ellen, *Observer*, 15 April

THE HISTORY OF PROHIBITION proves it fuels gangsterism and forces up potency, from moonshine replacing beer and wine almost a century ago in the United States through to skunk ousting milder cannabis on British streets. Stronger products mean smaller quantities for smuggling, bigger profits and more turf fights... When will Westminster accept its lethal failure on this battlefront? We have the highest rates of heroin use and almost one in three of the overdose deaths in Europe. Our mortality rate is ten times that of Portugal, where addiction is treated as a health issue, not a crime. It slashed heroin abuse after decriminalising drugs. British politicians are acting with criminal incompetence as other countries start to end this stupid war and focus on harm reduction.
Ian Birrell, *Times*, 18 April

THERE ARE DRUG INJECTION FACILITIES in almost 70 cities around the world, but not one in the UK. That is because of outdated laws that the UK government must either change or devolve to Scotland. There were 867 drug-related deaths in Scotland last year and countless other lives were devastated. How many of those people would still be alive if they were in a safe environment, using clean equipment and with medical professionals on hand?
Aileen Campbell, *Herald*, 9 April

'I cannot help wondering why everyone wants to prolong a life that will inevitably be joyless...'

SHOUTY HEADLINES ON FRIDAY MORNING proclaimed: 'Couple of glasses a night shortens life by two years! Much more than four bottles a week can lop off five years!' By that count, I should have died four years ago... I have always wondered about the veracity of these scare stories, thinking, well, what if your wine glasses are really small? And I cannot help wondering why everyone wants to prolong a life that will inevitably be joyless, as if this were our only ambition.
Liz Jones, *Mail On Sunday*, 15 April

National judo champion **Stuart Pascoe** thought his sports career was over as his alcohol use spiralled. But with help from Addaction the 46-year-old has gone on to beat competitors half his age, as well as volunteering with the charity to help people experiencing similar problems

RESOUNDING VICTORY

I STARTED DRINKING EXCESSIVELY AFTER MY DIVORCE. I tried to run away from what was happening and travelled around working, living out of a suitcase. But I should've stayed and dealt with things. I've always been a reward drinker, so throwing myself into work and achieving gave me the perfect opportunity to drink every night. But that gradually became drinking in the morning and going home at lunchtime to drink.

All those years ago I didn't realise that places like Addaction existed. I can remember my mum coming with me to my first meeting because I was shaking with nerves. Looking around the room I realised this illness doesn't discriminate – there were people from all walks of life, and of all ages. I never imagined meeting a group of like-minded, supportive people I would go on to call friends.

I went to Addaction Chy, the charity's rehabilitation centre in Truro, but I wasn't ready and got very complacent. I thought I was fixed after five months and that I could jump back into my old life. I told myself I could manage it, that the old me was back and I was where I wanted to be. I was so wrong. It went downhill in months and within a year I was out of work. The loneliness started creeping in, I stopped seeing family or doing judo, and I isolated myself with nowhere to go.

'I've always been a reward drinker, so throwing myself into work and achieving gave me the perfect opportunity to drink every night.'

Stuart at Addaction Chy with manager Ross Dunstan

At the worst point I was drinking about 1.5 litres of vodka a day and not leaving the room I was staying in. I'd send a taxi to the shop to get a bottle and lock myself away all day. I didn't eat when I was drinking, I was so alone, and nobody saw me for about six months.

I was up and down all the time, crying one minute, laughing the next, hallucinating and having vivid dreams. My body was failing and I was being sick all the time. Friends and family can only do so much, and I had pushed them all away so many times.

My wake-up call was a visit from the doctor who told me I would be dead in six to eight weeks and wouldn't see Christmas if I carried on. I knew this was it, but if I was going to change I didn't have time to wait around. So I did a detox in hospital and luckily Addaction Chy was able to get me in quickly.

This time I stayed 12 weeks in the main house and then did three months in the move-on flats, rather than jumping back into the community. I focused on getting things back in my life that were healthy and not worrying about work. Judo had been part of my life for 40 years and I wanted to get back into it. I'd won a couple of national championships before, but retired in 2003. I decided to set myself the goal of winning the British championships and started training that September.

Nine weeks later I won the open-age category, competing against people half my age – the guy on the silver podium said his dad was younger than me. It was the first competitive judo I'd done in 14 years and it put me among the oldest champions ever. I'd had aspirations to go back into it before, but the alcohol got in the way.

Now I'm eligible to train with the national squad and the British masters squad. The rest of the time I train locally at Redruth Judo Club where people have been really supportive, and sometimes at Helston and Plymouth. Next I'm planning to compete in the British Judo Council open nationals.

Volunteering with Addaction and judo are my life now. I run some of the charity's mutual aid groups, prep for treatment groups and am a mentor to new clients. I'm also volunteering at Chy, running the introductions group for people who are in their first four weeks of rehab.

My life is a dream now. This afternoon I will go and mentor clients before going to work tonight, then my weekend will be filled with catching up with friends and watching some judo. It's been a hard journey, but thanks to Addaction I made it to the other side and now I want to spend my time helping others do the same.

Phoenix Futures share the growth of their exciting Purple Camel Project

RECOVERING THROUGH NATURE

AT PHOENIX FUTURES we have been working with people with substance misuse issues for over 47 years, offering specialist services across community, prison and residential settings. Our fundamental belief is that every person who is dependent on drugs and alcohol has the potential to rebuild their life.

It is only by focusing on an individual's wider recovery, however, that lives can be rebuilt and individuals can stay on track. So in addition to our core recovery services we also offer a number of personal development programmes that help service users gain skills, confidence, motivation, employment and reintegrate into their communities. The longest running and most successful of these programmes is Recovery through Nature (RtN).

'Purple Camels' is a holistic approach to developing sustainable recovery. The guiding principles are oriented around growing as much of our own produce as possible in our gardens and allotments, to be used in our kitchens. We source local produce, if and where cheaper (including environmentally preferable purchasing), and have developed a culture of recycling and being aware of the way we use and save water and the energy for heating and lighting. We look at the use of renewable resources across the spectrum and are aware of pollution.

We called the project 'Purple Camels' because camels are able to adapt and survive in challenging environments, and purple is Phoenix Futures' colour. The programme is part of the organisation's Recovery through Nature programme – a highly effective therapeutic intervention that engages teams of service users recovering from substance addiction in practical conservation projects, and uses that experience to support their rehabilitation and recovery.

There are two fundamental guiding principles to 'Purple Camels'. Firstly, the idea must be incorporated into the therapeutic community (TC) process as part of a 'right living' ethos, and be service user-led and orientated. It links into the proven, underpinned benefits of eco-therapy, horticultural therapy and our own Recovery through Nature programme and becomes integral to our TC process. Secondly, as an organisation, we are making a conscious effort to reduce our costs in such straitened times, so the intention is that it will save money in the long term and make our approach unique.

Working in partnership with Lane End Farm Trust (LEFT) at Phoenix Futures' Sheffield residential service brings together our expertise to develop the desired sustainable concept. Our aim is to collaborate on a sustainable food cycle programme by developing the large, walled, Victorian garden at its Storth Oaks site into a kitchen garden of raised growing beds. The intention is to create a vegetable and fruit growing garden that can supply seasonal organic produce for the kitchen at the residential service, and any surplus produce can be sold into the local food community working with the Lane End Farm Trust (LEFT) existing customer network. In addition to the raised beds, we intend to have a poly tunnel on site to extend the growing season and provide better growing conditions to produce a wider variety of produce for more months of the year.

Service users from both PF and LEFT will have access to working in the garden across all stages of the growing season, and trained staff with horticulture and therapeutic horticulture experience will provide guidance and training for service users. As the project develops, we intend to provide basic qualifications for service users who wish to engage in that part of the programme. Other users may simply benefit from the chance to be involved in a real work environment and gain empowerment through the therapeutic benefits of horticulture.

The benefit to the wider community, including local residents, volunteers and support workers, is access to high quality ethically produced food at fair prices that is grown and harvested by our service users. This ultimately improves community cohesion through inclusive outreach across the local area.

> 'It is only by focusing on an individual's wider recovery that lives can be rebuilt and individuals can stay on track.'

Work began to transform the gardens with raised beds on 16 April. It was discovered that the quality of the soil was excellent and the decision was made to move the programme forward rapidly, so service users planted the first crop of potatoes on 24 April – potatoes being chosen as the first crop so the soil may be thoroughly worked over when they are harvested.

REC-PATH
RECOVERY PATHWAYS

Have you ever had a problem with drugs?

Have you overcome your problem with or without help?

If the answer to both of these is yes, then we'd really love to hear from you; we want to know how you did it. Sheffield Hallam University is leading a three year study, across four countries looking at the different ways people have overcome their former drug problem.

Please take a look at our survey https://www.rec-path.co.uk/

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