DRINK AND DRUGS NEWS

DDN

ISSN 1755-6236 **JUNE 2018**

INSIDE:
EIGHT-PAGE ALCOHOL AND HEALTH PULLOUT

OUT OF THE SHADOWS

IS CRACK BECOMING MORE SOCIALLY ACCEPTABLE?

Plus: Is service user involvement still fit for purpose?

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EDITOR'S LETTER

'There was no suggestion of being silenced'

We could be about to see a big upsurge in crack use – but are we ready for it? How seriously should we treat the reappearance of 'crack horror' warnings? In this month's cover story, Kevin Flemen suggests a pragmatic response.

With so many different drugs in circulation and symptoms to look out for, we've been developing our DDN 'Wider Health' series, beginning with a centre-pages pullout on alcohol. As Steve Brinksman points out in his latest Post-it, many patients present with health issues that are not obviously linked to drug or alcohol use. Our at-a-glance guide will help to understand conditions in which alcohol is a contributory factor and is designed with non-specialists in mind, to create better pathways across all branches of healthcare. Please pass it to colleagues where you can – the pdf is freely available on our website. We are very grateful for Alcohol Research UK for supporting us to develop this resource.

In creating advice pages, let's not forget that most crucial part of the equation – service user involvement. When we started DDN nearly 14 years ago 'Nothing about us without us' was an essential theme. When Alan Joyce wrote his piece in 2006 (page 9) there was plenty to campaign for, but no suggestion of the patient voice being silenced. So Nick Goldstein's questions on page 8 about the health of service user involvement deserve our full attention. We may need to consider a different model, but the need for a clear and challenging voice has never been greater.

Claire Brown, editor

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

CJ Wellings

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

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

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by RalphTV / iStock

DDN is an independent publication, entirely funded by advertising.

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REGULATED CANNABIS MARKET WOULD GENERATE '£1BN' IN TAX

INTRODUCING A LEGALISED, REGULATED CANNABIS MARKET in the UK would generate 'at least £1bn in tax income, if not more', according to a report from the Health Poverty Action NGO. The money could then be ring-fenced to support the NHS as well as education and harm reduction programmes, it says.

With the Canadian senate about to vote on legalising cannabis for recreational use as *DDN* went to press, regulation and legalisation is 'an idea whose time has come', says the report, adding that a legal market 'could' also reduce alcohol consumption among some groups. Other benefits would include better labelling and consumer choice, safer and less potent products and more effective harm reduction.

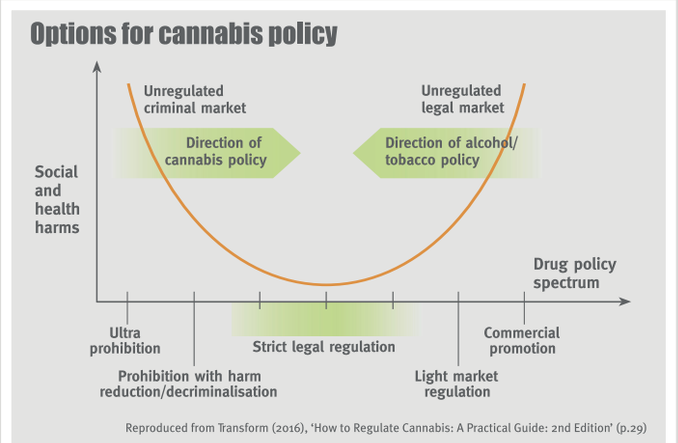
While the report accepts the 'possibility' that a legal market may mean increased levels of use, this would be balanced by the levels of revenue generated and by 'decimating' the criminal market. The NGO wants to see the government shift primary responsibility for drug policy to the Department of Health (DH) and the Department for International Development (DFID), as well as establish a panel of experts to develop an effective model for a regulated market. A Cannabis Regulatory Authority should then be set up to implement their recommendations, it says.

'It is time to accept that prohibition is not only ineffective and expensive, but that regulation could – if it is done well – protect vulnerable groups and promote public health,' the report states. 'It would also generate both taxes (at least £1bn annually, but potentially more) and savings, which taken together would mean more resources for health, harm reduction and other public services. It is time for the UK government to catch up with the global shift and take the responsible approach by bringing in a regulated, legal market for cannabis.'

Meanwhile, a separate report from the Taxpayers' Alliance says that legalisation could mean potential savings to the public purse of at least £891m a year. 'The prohibition of cannabis places a significant burden on public finances,' states the document, which claims legalisation would result in savings of £50m for the prison system, £21m for the CPS, £26m for the courts and £141m for the probation service, as well as significant gains for the police and NHS.

Cannabis: Regulate it. Tax it. Support the NHS. Promote public health at www.healthpovertyaction.org

Potential savings from the legalisation of cannabis at www.taxpayersalliance.com



Reproduced from Transform (2016), 'How to Regulate Cannabis: A Practical Guide: 2nd Edition' (p.29)

'It is time for the UK government to catch up with the global shift and... bring in a regulated, legal market for cannabis.'

PREFERRED PATHWAYS

UPDATED GUIDANCE on referring alcohol-dependent patients from hospital to specialist treatment has been published by Public Health England (PHE). The document is designed to illustrate what helps provide a 'smooth passage' through treatment, says PHE. Meanwhile, a new report from the Institute of Alcohol Studies looks at the policy positions of public health organisations and the drinks industry post-Brexit. Industry attempts to weaken regulation and increase both its influence over trade negotiations and its access to emerging markets will need 'particular scrutiny', it says.

Developing pathways for referring patients from secondary care to specialist alcohol treatment at www.gov.uk; Brexit battlegrounds at http://www.ias.org.uk; See DDN's alcohol health supplement, this issue.

TERMINAL DIAGNOSIS

THE MAXIMUM STAKE THAT SOMEONE CAN GAMBLE on Fixed Odds Betting Terminals (FOBTs) is to be cut from £100 to £2 to reduce the risk of 'gambling-related harm'. MPs and campaigners have been calling for a reduction in the maximum stake for years (*DDN*, September 2014, page 6), with the controversial terminals frequently referred to as the 'crack cocaine of gambling'. It is estimated that FOBTs account for around half of betting shop takings and the Association of British Bookmakers has said that it expects more than 4,000 shops to close. Digital, culture, media and sport secretary Matt Hancock, however, said the terminals were a 'social blight' that preyed on the vulnerable. PHE will also carry out a review of the evidence around the public health harms of gambling, the government has announced.

SPELL IT OUT

Drinkers support the clearer labelling of alcohol products – including calorie, unit and health information – according to research by the University of Bristol. Current labelling developed under the government's alcohol responsibility deal is 'low in effectiveness', researchers found. 'The voluntary labelling scheme clearly hasn't worked,' said Alcohol Research UK and Alcohol Concern chief executive, Dr Richard Piper. 'We need a strong and effective alcohol labelling system that provides consumers with the information they need to make informed lifestyle choices about their health.' *Findings at www.bris.ac.uk/news/2018/may/alcohol-labelling-.html*

SECONDHAND SPICE

THE WIDESPREAD USE OF SYNTHETIC CANNABINOIDS like 'spice' in UK prisons is risking the health of nurses and other staff, according to the Royal College of Nursing (RCN). Nurses and healthcare assistants are often first on the scene when prisoners need emergency care, and current guidance means they are expected to enter cells before any smoke has cleared. The RCN says at least one of its members has been taken to A&E after being rendered unconscious by drug fumes, while others have reported feeling dizzy, nauseous or being unable to drive after their shift. 'As dedicated health professionals prison nursing staff are expected to offer high quality care, but they should not be expected to put their own wellbeing on the line to deliver it,' said RCN chief executive Janet Davies.

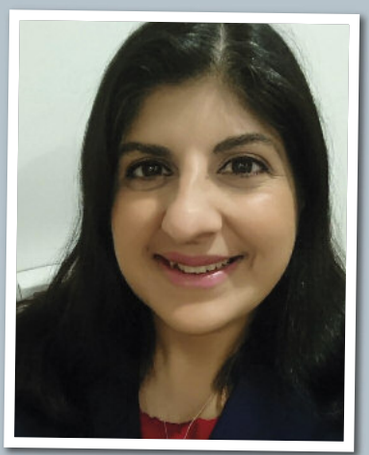
'Nursing staff should not be expected to put their own well-being on the line'

JANET DAVIS

MORE THAN HALF TEST POSITIVE IN COMMUNITY HEP C PILOT

A PILOT PROJECT OFFERING HEPATITIS C TESTING in pharmacies with needle exchange facilities has been hailed a success, with more than 50 per cent of those tested in the four-month scheme having hepatitis C antibodies. Almost 80 per cent of those who engaged with specialist services, meanwhile, had hep C viral particles in their blood.

A report from the London Joint Working Group on Substance Use and Hepatitis C (LJWG) highlights the need for further awareness-raising, as 57 per cent of those taking part were unaware that medical advances meant the virus could be treated with oral tablets rather than painful interferon injections. The pilot – which was carried out at nine pharmacies across London – demonstrates the potential for offering treatment alongside testing, says LJWG, as 84 per cent of participants said they would be happy to receive treatment at their local pharmacy.



'We will transform and save lives as well as preventing further virus transmissions...'
DR SUMAN VERMA

Innovative testing initiatives were essential in order to diagnose and treat everyone who has the virus, said public health minister Steve Brine, who added that the government was still working to eliminate hep C by 2025. It is thought that around half of the estimated 160,000 people in England living with the virus remain undiagnosed, and a recent report from the All Party Parliamentary Group on Liver Health stated that 'significantly greater' numbers of people would need to be tested, diagnosed and treated if it were to be successfully eliminated *(DDN*, April, page 4).

'This project is another great example of how community pharmacists and their teams can support the health of their local communities and engage with people who may be reluctant to go to their GP,' said chief executive of Kensington, Chelsea and Westminster Local Pharmaceutical Committee, Rekha Shah.

'We now have the treatments to eliminate hepatitis C as a serious public health concern in the UK,' added LJWG co-chair and consultant hepatologist at Chelsea and Westminster Hospital, Dr Suman Verma. 'Offering free, accessible hepatitis C testing in community pharmacies is a more patient-centric way of engaging with a group of vulnerable, young people where hepatitis C prevalence and risk of transmission is high but, due to personal and social circumstances, engagement with community drugs services or healthcare services in general is poor and sporadic.

'By offering hepatitis C testing in community pharmacies, we will transform and save lives as well as preventing further virus transmissions. This pilot project has the potential to be developed further to encompass the provision of hepatitis C antiviral treatment directly in the community pharmacies for this vulnerable, socially marginalised, at-risk population.'

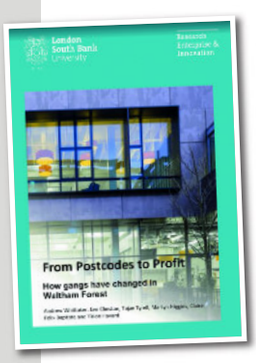
Report at ljwg.org.uk

See our September issue for the DDN wider health supplement on hepatitis C.

MARKET MATTERS

LONDON GANG TERRITORY is now more likely to be defined by a drug marketplace 'that needs to be maintained' than a postcode, according to a report from London Southbank University (LSBU). The emphasis on financial gain is also exhibited through alliances with other gangs and aggressive 'county lines' expansion, says *From postcodes to profit*, which was commissioned by Waltham Forest Council. Women and girls are increasingly used by the gangs to carry drugs, exposing them to violence and sexual exploitation, it adds. 'What is striking is how ruthless and exploitative some gangs have become,' said associate professor of social work at LSBU, Andrew Whittaker. 'Six out of ten gang members have anxiety disorders including post-traumatic stress disorder and a third will have attempted suicide.' *Report at walthamforest.gov.uk*

'Women and girls are increasingly used by the gangs to carry drugs.'



OUT OF CONTROL

LAST YEAR'S RECORD OPIUM CULTIVATION IN AFGHANISTAN (*DDN*, December/January, page 4) is leading to 'unprecedented levels' of potential heroin production, says the latest UNODC survey. Cultivation jumped by 63 per cent from 2016 levels, which means up to 900 tons of export-quality heroin with a purity of between 50 and 70 per cent could be produced, says *Afghanistan opium survey 2017: challenges to sustainable development, peace and security*. In the southern region of the country farmers now cultivate opium poppy in nearly 85 per cent of villages, with insecurity and lack of government control 'a clear and well-established link' to increased production. 'Only a small share of the revenues generated by the cultivation and trafficking of Afghan opiates reaches Afghan drug trafficking groups,' says UNODC. 'Many more billions of dollars are made from trafficking opiates into major consumer markets, mainly in Europe and Asia.'
Document at www.unodc.org

IN THE DARK

THE UK CONTINUES TO HAVE SOME OF THE HIGHEST RATES OF 'DARK NET' DRUG PURCHASING in the world, according to the latest Global Drug Survey. More than 24 per cent of British respondents said they'd accessed substances in this way, behind only the Finns and Norwegians. MDMA, cannabis, LSD and NPS were the most commonly bought drugs.
www.globaldrugsurvey.com

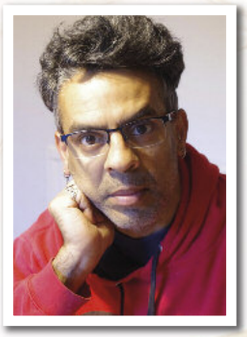
DEATHLY FIGURES

THE FIRST OVERVIEW OF DRUG-RELATED HOMICIDE RATES IN EUROPE has been produced by EMCDDA. Comparing statistics between countries can identify trends and help authorities to plan proportionate responses, says the agency, adding that the issue is 'of serious concern in relation to the overall security situation in Europe and deeply affects communities at large, as drug use and drug markets can act as cross-cutting facilitators of acts of violence'. *Drug-related homicide in Europe: a first review of the data and literature at www.emcdda.europa.eu*

COLLECTIVE GROWTH

Exeter-based EDP Drug & Alcohol Services is the latest organisation to become part of Collective Voice, bringing the number of voluntary sector members to eight. 'EDP brings a wealth of experience from delivering a range of substance misuse services in the South West,' said Collective Voice chair Karen Biggs. 'We look forward to working with an expanding membership going forward.'

CRACKS IN THE MIRROR



Could a recent growth in crack cocaine use indicate its move to social acceptability – and how should we respond? **Kevin Flemen** examines the situation

Stigma-driven barriers between powder cocaine and crack may be breaking down. Increased availability of crack thanks to 'county lines', combined with increased demand and reduced stigma, could see a big upsurge in crack use. But are drug services ready for a growing population of dependent stimulant users?

'They weren't finding their coke use so rewarding anymore... so they've moved in to smoking crack.'

This observation by a participant in a recent stimulant training day echoed comments that have been coming up more frequently of late, and it made me very anxious. The users in question had been trades or construction workers in the Telford area. Historically this would have been a cohort who found powder cocaine highly acceptable but would have viewed crack cocaine less favourably. That they were migrating from cocaine powder to crack suggested not just changes in availability of crack, but also changes in attitude.

Crack cocaine has, generally, not enjoyed the same kudos and acceptance as cocaine powder. The stereotypes and assumptions – a highly addictive, 'ghetto' drug associated with crime, impoverishment and squalor – were on the one hand highly stigmatising. But on the other they acted as a buffer, as many people viewed cocaine powder as 'acceptable' but crack cocaine as a 'dirty', unacceptable drug.

Granted, there had always been those who didn't subscribe to this simplistic view and there were a fair few North London types who used to drift in to Dalston to sample the dubious pleasures of a crack house before heading back to less edgy areas. There were numerous 'Professionals Binge on Crack' type stories in the media 20 years ago (*The Guardian*, 13 November 2000), but this didn't translate to more widespread usage.

The drugs field too had more than a few of its own workers who believed that the demonisation of crack was unwarranted and that they were more than capable of handling crack or making their own freebase. Some fared OK, others less so.

These exceptions aside, the prevailing view of crack as a 'bad' drug would, once upon a time, have meant that the Telford trades workers mentioned earlier would generally not have gone near crack.

'My brother works on a construction site and he's in his forties. He's just walked off a job because at the end of the day the rest of the crew are all sitting in the cabin smoking crack.'

On all recent courses I've been exploring the issue, and repeatedly, similar examples have emerged – established white working-class trades and construction workers who, finding powder cocaine less rewarding, are putting down the tube and picking up the pipe. But subsequent cases suggest that the issue is more widespread.

'Some of my "friends" have been smoking rocks too. They were finding that their noses were hurting too much from cocaine, so switched to rocks.'

'All the cool and edgy kids are doing it. They all go off to a room at the end of the evening or at parties and are smoking rocks. They'd been dipping cigarettes in cocaine and it moved from there.'

The first of these examples was a recently graduated social work student in Staffordshire, and the second related to the artist community in increasingly-gentrified Hackney Wick. They highlighted to me that the increased access and acceptability of crack was resulting in take-up across a range of different social settings.

Availability of crack has increased at least in part because of the 'county lines' phenomenon, and we are seeing crack markets emerging in areas where it had previously not been a significant issue. These markets had, however, often piggy-backed onto existing opiate markets – expanding market share by offering two-for-one deals or mixed 'any five for £30' offers, where the buyer could have four rocks and a bag of heroin for the comedown, or three bags of heroin for an opiate habit and two rocks as a 'treat'.

This expansion into existing heroin markets is, of course, in itself problematic. Experience says that the stability and health of heroin users often markedly deteriorates when they add crack to their repertoire. Treatment requirements change dramatically and engagement can be more difficult. But my tacit assumption was that the size of the market for crack was limited by the size of the heroin market it was latching on to. The stigma relating to crack in the past had offered a degree of protection.

What, then, if that stigma has been significantly eroded? What if even just 10-15 per cent of our existing cocaine users start to migrate to crack use? How big would that population be, and how well set up are services to identify and respond to it?

More on crack cocaine at www.drinkanddrugsnews.com

Alec Macdonald / Alamy Stock Photo

Espiritusanctus

Stigma is of course a double-edged sword. It may well in the past have deterred people from using crack. But that stigma also reduced access to services. Some activists in the field, such as Mat Southwell, argued that 'the demonisation of the drug and its users has fostered the belief that crack cannot be managed.' Offer empowerment and tools for control and we could change behaviour went the argument: http://www.drugwise.org.uk/wp-content/uploads/More-than-a-pipe-dream.pdf

Others, such as Peter McDermott, writing around the same time challenged this model and the prospects of 'managed' crack use for the majority of users: http://www.drugwise.org.uk/wp-content/uploads/Crack-harm-reduction.pdf

So it will be interesting to see the extent to which the current cohort of asset-rich crack users, unencumbered by the mythos of crack as an unmanageable drug are, in fact, able to manage their crack use – or if it spirals out of control.

If, as I fear, we are starting to see an upsurge in crack use which sprawls beyond a core demographic, services are going to have to get ready and, fast. In 2003/4, when the government and the NTA saw growing levels of crack use as an issue, resources were put in place, regions and agencies were encouraged to develop stimulant strategies and some areas appointed lead workers to address the issue.

Although levels of crack use increased, the feared 'crack epidemic' never materialised as envisaged and these strategies gradually got subsumed by other agendas and strategies.

If, as I suspect, we are going to see a marked increase in crack presentations, the useful aspects of these strategies need to be exhumed and brought up to date. We also need to learn what didn't work and not repeat these mistakes.

As there is currently no model of substitute prescribing for crack, some workers feel disempowered and people with crack dependencies may feel that there is little on offer for them. Services therefore need to ensure that through training and resources, staff are empowered to respond confidently to people presenting with crack dependency.

Regionally, outreach, GP liaison and arrest referral will be useful in determining the scale of the issue locally. As this nascent crack using population aren't currently injecting or heroin-using, they won't automatically have contact with drug services via, for example, needle exchange.

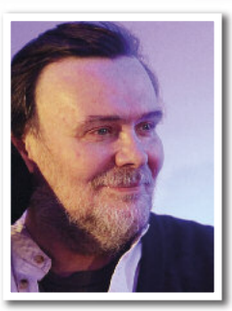
Harm reduction interventions, including resources to address the needs of crack smokers, polydrug users (including crack and alcohol, use of opiates or benzos as comedown drugs) and crack injectors need to be in place. Drug-related deaths strategies should also address responses to critical incidents involving crack, including the need for rapid ambulance attendance and CPR.

Services need to ensure that they have the capacity to deliver a rapidly accessible service to clients in chaos, who may need numerous brief interventions over a short period of time. Structured, evidence-based day programmes, craving management interventions, and healthcare to address physical and mental health problems stemming from crack use, need to be in place sooner rather than later.

It's always risky pressing the button marked 'crack problem', as it's been pushed too often. But I'm probably more anxious about crack this time around than I have ever been working in the field. I hope I'm wrong.

Kevin Flemen runs the drugs education and training initiative, KFx

A patient worth saving?



We need to talk about service user involvement, says **Nick Goldstein**

Service user involvement, in one form or another, has been around a long time. An argument could be made that it's been around since Hippocrates carved healing out of theology, superstition and belief to create modern medicine. He actually asked his patients to describe their symptoms and how their treatment was going and used their feedback to improve treatment, which sounds familiar.

Service user groups arrived in modern Britain with the forming of community health councils in 1974. Their stated aim was to allow the 'public' to participate in their own health and social care – and that public included service users.

The arrival of New Labour in 1997 marked the apogee of service user involvement in Britain. One of the government's first acts was to legislate for greater public engagement in healthcare, so the NTA, PCTs et al all promoted, encouraged and even funded service user groups. But even at its peak, service user involvement often gave the impression of being an afterthought – something that had become a legislative obligation and hence tolerated by service providers, rather than a concept that was loved and appreciated.

A change of government in 2010 brought a change of agenda and the beginning of the decline of service user involvement. The adoption of the recovery agenda resulted in recovery-orientated services and recovery-focused service user groups, and their concentration on life post treatment meant that much of the emphasis on improving treatment and policy was lost. It also resulted in funding cuts, making it difficult to operate meaningful service user groups and furthering the disinterest in service user groups and what they had to say.

This is where service user involvement languishes at present – as an underfunded afterthought that only really exists to tick boxes. To be clear, service user involvement is gravely ill. The question is, is the patient worth saving?

The question alone will be heresy to some, but maybe the time has come to examine what service user involvement was supposed to be, what it actually became, and what it should be. Its initial aim was to empower users to improve their own health by involving them in partnerships with service providers, to improve and monitor services. That's actually two subtly different aims – and that schism between the two aims is the root of the problem.

Firstly, there's service user involvement as therapy for users. This could be sarcastically referred to as the service user involvement of pony riding trips and opera visits, but it would be short sighted or wilful blindness not to accept that it provides vital support and structure to many service users who are already marginalised.

It's the second aim that's the problem. Service user involvement has, and will, continue to be an abject failure in providing user expertise in improving services

More on user involvement at www.drinkanddrugsnews.com

and holding service providers to account.

The reasons for this failing range from the inclusive, democratic nature of the service user involvement model failing to provide the necessary level of expertise in its representatives; through to the reluctance of professional service providers to listen to amateur service users and the stigma that can be found in professional service providers' reluctance to listen to a bunch of drug users.

Service user involvement in other areas of health and social care also suffers from this, although not to the same degree as substance misuse user groups. It seems that a service provider's approach to it is directly proportionate to their preconceptions of their service users in general – which can be just as negative as those found in the general public. The blame for using such a flawed model can be spread around, but the bottom line is that service user involvement as a model fails to have an impact on treatment policy.

*****

While writing this article I called several leading lights from service user involvement for research, and one question I asked them all was to name one national policy change that has been driven solely by service users. I'm still waiting for someone to come up with one – a silence that speaks volumes.

'I called several leading lights from service user involvement for research, and one question I asked them all was to name one national policy change that has been driven solely by service users. I'm still waiting for someone to come up with one....'

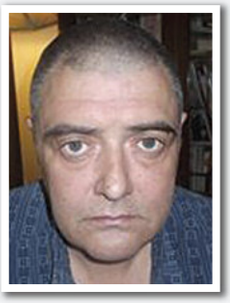
Substance misuse services are approaching major change – partly the result of changes to patterns of drug use, partly due to significant funding cuts – and it's essential drug users engage with civil servants, politicians and treatment providers to ensure 'best practice' maximises resources and is as beneficial to drug users as possible. Service user involvement has repeatedly failed to provide a means of meaningful policy engagement and there's no reason to believe this will change in the future. Consequently it's imperative for all parties to find an alternative model.

This search for a functioning model doesn't mean it's the end of the road for service user engagement. Rather, what's needed is an acceptance of the model's limitations and a reappraisal of how to maximise its potential. Its sole aim needs to become a therapeutic tool for users on a local level, where its organic development can be supported by service providers. A meaningful service user group is always organic because it requires at least one service user, preferably with links to the local community, to manage and lead it. They cannot be artificially created or manufactured, but should rather be appreciated and supported whenever and wherever they flower.

I've been around substance misuse treatment long enough to see the pendulum swing back and forth, and in time the pendulum will swing back to favouring patient participation again. When it does, let's be realistic regarding service user involvement's role. What it does well should be supported – and for what it can't do, we need to find another model.

Nick Goldstein is a service user

Nothing about us...



In January 2006, Alan Joyce told DDN why effective service user involvement was so vital. This extract shows that his words are as relevant today as they were 12 years ago

There is overt hostility on the part of some practitioners to the very idea of 'treating' drug users, exemplified in the words of one GP to a patient for whom I advocated: 'I am not here to provide you with free drugs. Come back when you are clean.' Then there is the intimidating surgery receptionist who discusses the patient's medical history or drug problem in front of other patients in the waiting room. The user feels so unwelcome at the practice that they leave and take their problem elsewhere.

If the user makes it beyond the surgery door to find a doctor who will treat them, they will still face continuing problems. One chronic problem is under prescribing – or more correctly, sub-therapeutic dosing. Many GPs prescribe methadone at levels way below government guidelines, refusing to consider a realistic dose. Understandably patients continue using on top, or relapse, and treatment is routinely associated with poor outcomes.

Another common problem is a punitive response to a user exhibiting symptoms of their condition. Opiate use is described as a chronic medical condition characterised by relapse. In no other branch of medical treatment would a patient exhibiting a classic symptom of their condition find their treatment withdrawn on 'punitive' grounds.

Overly rigid prescribing and dispensing practice can cause further problems. While it is understandable that supervised consumption may often be a necessary and appropriate measure to be taken when initiating, prescribing and stabilising the patient, it can all too often be applied in a dogmatic and inflexible manner that makes it very difficult for certain patients to remain in treatment.

Another common problem is a refusal by some GPs providing treatment to follow the science or evidence base – or even current guidelines. The right to exercise 'independent clinical judgement' is deployed as a fig leaf to cover what is, at best, down to poor training and ignorance – or at worst the doctor's imposition of their own personal morality and belief system on the patient.

In some medical practitioners, this can give rise to a fixation on abstinence-based recovery. While for some users cessation of drug use is a laudable and achievable goal, for many others it is not. Other treatment options that focus on harm reduction and maintenance are denied to such patients. Sometimes this can have a drastic impact on treatment provision in a whole region, and we can identify such 'problem' areas by the number and type of cases we receive. Sadly, one can also identify such areas by high overdose and drug related mortality rates.

By listening to the patient's voice, both drug user and treatment provider will cease to find themselves in an enforced embrace characterised by mutual misunderstanding, incomprehension, distrust and antagonism, and become equals in a therapeutic alliance.

Alan Joyce was senior advocate of the Alliance. He died in 2013 but his work is remembered by many. His article, *Why do we need user advocates?* was published in *DDN*, 16 January 2006, page 12.

THE PRICE OF A DRINK

Alcohol misuse is causing huge damage to the nation's health and its finances. With minimum pricing finally a reality in Scotland, what does the future look like for the rest of the country? **DDN** reports

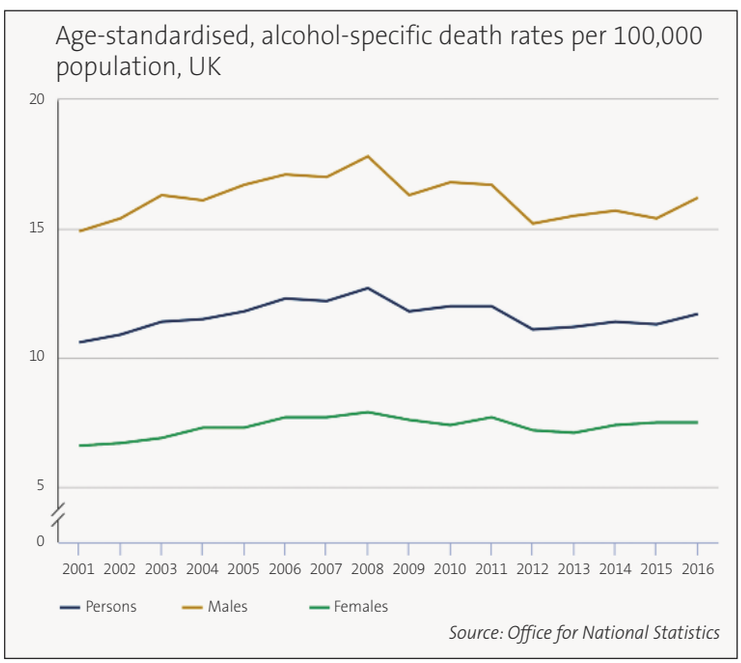
ACCORDING TO THE MOST RECENT FIGURES from the Office for National Statistics (ONS), the number of 'alcohol-specific' deaths in the UK stands at more than 7,300 (*DDN*, December/January, page 5). While the death rate does appear to have plateaued in recent years, it's still higher than at the turn of the century and ONS stresses that the narrow definition of 'alcohol-specific' means those numbers will be a conservative estimate.

Much has been made of the fact that fewer young people seem to be drinking, but those that are, are drinking a lot. Death rates among older people, meanwhile, are rising steeply – by around 50 per cent since 2001 among men aged 70-74, for example. As this issue's *Alcohol and Health* supplement points out, it can be decades before the damage done to a liver by heavy drinking manifests any symptoms, and often when it's too late.

Clearly, then, there's no cause for complacency, and while calls for better labelling (*DDN*, February, page 5) have yet to show results, the battle to introduce minimum unit pricing (MUP) has finally been won, albeit after a five-year fight (*DDN*, December/January, page 4). MUP became law in Scotland last month, and Wales is also moving to introduce it (*DDN*, November 2017, page 4). So are we likely to see it in England?

'We will have to wait and see,' director of policy at Alcohol Research UK and Alcohol Concern, Dr James Nicholls, tells *DDN*. 'I think it's unlikely in the short term, not least because the government is tied up with Brexit. They have announced that a new alcohol strategy will be developed, but as regards MUP it sounds like that will only involve a review of the evidence. They are also waiting to see what the outcome is in Scotland, where we now have the opportunity to see how the policy plays out in the real world.'

All eyes will be looking north of the border, not least because up to now everyone has had to rely on modelling predictions for MUP, Nicholls points out. 'That modelling is detailed and extensive, but wasn't a crystal ball. Now that the policy is in place, everyone is looking to see how it plays out.' One very interested party, of course, is the drinks industry. Its battle with the Scottish Government went to the European Court of Justice and the Supreme Court, but it still lost, which means it's unlikely to mount any legal challenges to Welsh or English plans. 'The legal process leading up to the Supreme Court decision was lengthy and thorough, so I think the legal questions are largely resolved,' he says.



Source: Office for National Statistics

'Everyone is looking to see how it plays out'
JAMES NICHOLLS

The fact that it was so lengthy has led to criticism that the 50p level set is now too low, with the Scottish Lib Dems arguing 60p would better reflect the impact of inflation (*DDN*, March, page 5). Is that fair comment? 'There is a very extensive evaluation taking place in Scotland, which will look at the impact of the 50p price on different types of drinkers, on retail practices, and on health outcomes,' Nicholls states. 'That's a good thing – policies should be evaluated, and we should be prepared to adapt our view of them in line with what we find. The most important thing, at this stage, is to try and ensure the evaluation is robust and impartial – we can then develop our views on the future of MUP in the light of that understanding.'

While MUP may be a positive development, for those struggling with an alcohol problem it clearly isn't a silver bullet. Access to effective help is vital, and the recent report *The hardest hit* spelled out that the treatment system is at crisis point (*DDN*, May, page 4). One of the reasons identified was lack of political support – is that simply down to competing local priorities for limited funds, or is it a fundamental failure to see the bigger picture?

'I think it's very hard to make the case for better investment in substance use treatment generally, and alcohol treatment in particular,' says Nicholls. 'It's not really a popular cause, and there is often still the sense that this is government spending money on people who have brought problems on themselves. However, aside from the ethical responsibility to support people struggling to overcome dependency, disinvestment is clearly a false economy. If people can't get the support they need that doesn't mean their problems disappear – often those same people will end up as repeat visitors to A&E or to other social services, all of which has enormous cost implications. We are calling for concerted government action to tackle the crisis in alcohol treatment both because it is the right thing to do and because disinvestment in the system leads to enormous costs further down the line.'

As the government does finally seem to have committed to delivering a new alcohol strategy, what should be in it? Alongside action on marketing regulation and pricing his organisation wants to see a 'commitment to meaningful action on helping vulnerable people – not just those needing help with problem drinking, but the families and communities affected by that,' he says. 'That not only means more money for treatment, but support for better skills development and commissioning.

'For that reason, we are asking the government to look at the introduction of a levy on alcohol to plug the funding gap – we want better support for the range of services who encounter alcohol issues in their daily work, improved pathways into treatment, and more effective use of brief interventions.'

pavilion
drug and alcohol treatment

from dependence to freedom: achieve your potential with the Pavilion

The Pavilion is a stunning residential drug and alcohol treatment centre situated in picturesque private grounds, just outside Lancaster, with easy access from the M6.

Our 18 – bed facility delivers an approach that encompasses a combined clinical and therapeutic intervention that is delivered safely and effectively to support treatment completion.

Our team is made up of Doctors, Independent Prescribers, Nurses, Support Workers and Therapists. Our clinical team are available 24 hours a day for our patients.

The Pavilion offers a full health and wellbeing assessment, stabilisation on substitute medication, detoxification from a wide range of substances, access to holistic therapies including art therapy and mindfulness, along with space and time for personal reflection. We offer female only areas and access to "Breaking Free Online" (BFOL), AA and NA.

Our individually tailored, evidence based programmes are delivered by specialist practitioners throughout the admission duration which can be from 7 to 28 nights; this ensures treatment flexibility and optimum outcomes for all our patients.

When not in group or 1-1 sessions patients have access to our fully equipped on-site gym to help promote physical and mental wellbeing, as well as stunning communal gardens, TV lounges, family visiting areas and healthy and nutritional meals provided by our on-site chef.

We work collaboratively with all our patients to address a range of dependencies through clinical interventions, psycho-education and therapeutic programmes and development of aftercare programmes.

Here at The Pavilion we work closely with our patients to assist with transitioning onto rehabilitation packages and to other centres after completing their required stay with us.

From January 2017 to January 2018, 84 per cent of our patients successfully completed their treatment with us.

The Pavilion's admissions team are on hand to help seven days a week 9am – 9pm on **01524 39375**, email **enquiries@delphipavilion.co.uk** or chat confidentially to one of our trained advisors online. For our 'chat' service and more information please visit **www.delphipavilion.co.uk**

"I could not have had better care, compassion and commitment from every one of the staff. In my opinion they go over and above what is expected of them. Absolutely fabulous in every way."
Lisa, 53

Part of The calico Group

EXCO

Excellence in Commissioning for Opioid Use Disorder Services • Manchester, 22 June 2018

COMMISSIONERS CALL FO TO OPIOID USE DISORDER

Expert Faculty on Commissioning confirms speakers for 'EXCO', the first joint congress on excellence in commissioning for opioid use disorder

THE EXPERT FACULTY ON COMMISSIONING will hold the first integrated meeting for commissioners and other experts focused on opioid use disorder (OUD) care. The event on 22 June 2018 is entitled 'Excellence in Commissioning for Opioid Use Disorder' and includes 75 experts from across England who will debate the future of addiction care for people with serious drug problems.

Senior experts including Rosanna O'Connor (director of alcohol, drugs and tobacco, Public Health England), Prof Rod Thomson (director of public health, Shropshire) and Mark Moody (chief executive, Change, Grow, Live) will lead the discussions in the meeting with commissioners responsible for designing and overseeing drug treatment services.

Terry Pearson, responsible for commissioning drug and alcohol services for Northamptonshire Country Council and joint lead for the Expert Faculty, commented: 'There is significant innovation in the treatment of opioid use disorder – commissioners must act to ensure that we make the most appropriate use of new treatments and technologies avoiding unnecessary delays.'

INSIGHTS

The 'new' *Drug Strategy 2017* defines the goals and scope of OUD care in England and identifies the future challenge: 'Progress has been made in supporting people to recover from their dependence on drugs, but we need to go further.'

The 2017 'Orange Book' or *Drug misuse and dependence UK guidelines*, Public Health England (PHE) and the Advisory Council on the Misuse of Drugs (ACMD) inform the debate on best practice in OUD care.

It is noted that 'despite successes with falling numbers of young people currently developing heroin dependence, the morbidity, mortality and long-term needs of an ageing cohort of patients with long-term heroin dependence problems means that treatment is increasingly complex...'

The environment is not static – there is important change in progress and commissioners of drug treatment services must ensure the decisions they make reflect the new options innovation can deliver. For example, depot forms of medication, which do not have the inherent risks of oral treatments, may be approved in England. Commissioners in each of the local authority public health departments can now work together in the expert faculty for the first time. This collaboration will be key in the future; I encourage all commissioners and others involved in decision-making for drug treatment services to participate in the expert faculty.

Jayne Randall (drugs and alcohol strategic commissioner, Shropshire)

Development in the last 20 years led to a treatment system for OUD that achieved important successes, saving many lives and avoiding public health crises.

Some now observe the approach to treatment today has remained unchanged for many years and there is a need for innovation to address some of the problems experienced by those using the treatment system.

Problems with treatment reported include that many people are not in care, and some in treatment face worsening health and find it hard to get optimal care. Others may still be using on top or be involved in diversion of medications. Treatment is still associated

OR JOINED-UP APPROACH DECISION-MAKING

THE EXPERT FACULTY ON COMMISSIONING is an independent group of experts, formed in 2016, that aims to support commissioners by sharing experience and insights on best practice, with the overall goal of improving outcomes for people with OUD.

THE EXPERT FACULTY is independent and participants do not receive payment. Specific programmes are funded individually. The faculty works on a project basis with resources from all types of organisations and businesses. Organisations providing resources do not influence the thinking nor work of the faculty. Camurus AB, a company developing new medications for OUD, has provided funds for the logistics of the faculty annual congress.

ALL INTERESTED IN THE FUTURE OF INNOVATION in OUD care and the evolving role of commissioning are strongly recommended to join this event. Registration is free for those working in the field.

Please find more information and register at:
www.expertfaculty.org/exco

PLENARY SESSIONS

ROSANNA O'CONNOR, director of alcohol, drugs and tobacco, Public Health England
ROD THOMSON, director of public health, Shropshire Council
MARK MOODY, chief executive, Change, Grow, Live
STEWART ATKINSON, Office of Police and Crime Commissioner for Humberside
TERRY PEARSON, commissioning manager, Northamptonshire County Council
JAYNE RANDALL, drug and alcohol strategic commissioner, Shropshire Council
MARK GILMAN, Discovering Health, former PHE recovery lead
ANTHONY BULLOCK, senior commissioning manager, Staffordshire County Council
PAUL MUSGRAVE, senior manager, public health, Cumbria County Council
ANNEMARIE WARD, CEO of FAVOR
KERRIE HUDSON, operational lead, The Well Communities

WORKSHOP SESSIONS

Collaboration and innovation: building a modern approach to commissioning OUD Services

TONY MERCER, health improvement manager (alcohol and other drugs), Public Health England
WILL HAYDOCK, senior health programme advisor, Public Health Dorset
CHRIS LEE, public health specialist: behaviour change, Lancashire County Council
MARK WEBSTER, head of development in ACT Peer Recovery
DAVE VAUGHAN, service manager, Recovery Works Ltd
PAULA HARRIOTT, Prison Reform Trust

Decision-making, evidence and outcomes: planning for key choices in commissioned services using data

ROSIE WINYARD, public health commissioning lead, Worcestershire County Council
KAREN CASSIDY, public health specialist, Blackburn
CLIVE HALLAM, substance misuse commissioning manager at Wandsworth and Richmond Borough Councils
ANNETTE DALE-PERERA, chair of the recovery committee, Advisory Council on the Misuse of Drugs (ACMD)
JOHN BUCKNALL, commissioner, Halton Borough Council
HELEN PHILLIPS-JACKSON, strategic commissioning manager – substance misuse, Sheffield City Council
MARK KNIGHT, substance misuse lead, Greater Manchester Combined Authority

with problems including the risk of domestic exposure and harm to others.

IMPORTANT QUESTIONS ARE IN FOCUS:
Why do so many people not use treatment services at all? Do the individuals in care get a service that is flexible and targeted to their needs? Do we do everything to minimise risks?

Considering the approach we have today, is the burden of treatment too great? Does the regimen of daily treatment and obligations around collection of medications make treatment too much of a burden for some?

At the highest level, what is the treatment system for? Does the legacy system we work within deliver the results for the people we aim to service today?

With innovation on the way – including new digital tools for online help, new medications with weekly or monthly dosing and better use of integrated data systems to join up care – does the structure of the treatment system make it possible to achieve the best possible results for the 300,000 people with very important needs?

There is now an opportunity to review all the assumptions we make about OUD care and ask, with open eyes, 'What does good care really look like?', address the gaps in the current treatment system and decide how to improve outcomes for people with OUD.

The expert faculty works to challenge assumptions and, with the responsibilities of its members, ensure that commissioning is a key lever in the ongoing evolution of treatment services. It is time to act.

Mark Gilman (expert faculty participant, former PHE recovery lead)

POST-ITS FROM PRACTICE

AN EVER-DECREASING SHARE?

Allowing shared care to dwindle is putting patients' all-round physical and mental health at risk, says **Dr Steve Brinksman**

One of the things I am most proud of in the 27 years I have been a GP is the way many working in primary care responded to the challenges posed by treating substance misuse and dependency, with the resultant growth in shared care services. In Birmingham, where I am based, the number of practices providing OST rose from 8 per cent to over 65 per cent in a decade. I now fear that all this progress is under threat from multiple directions and if lost, all that experience and enthusiasm will be very difficult to replace.

'I now fear that all this progress is under threat from multiple directions.'

The years of austerity have been hard for many, but the move of public health into local authorities has opened up drug and alcohol treatment services to far more financial constraints than if they had remained inside health budgets. Retendering and enforced cuts in existing contracts have left providers with no option but to make significant changes. Some have been forced to merge, and despite what is supposed to be a culture of 'localism providing tailored local solutions', the number of options has dwindled. It is hard to see services being awarded to small local third sector organisations in this climate.

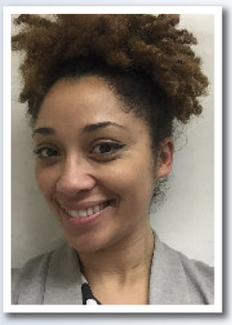
Where providers have to make cut-backs, the cost of providing services from multiple primary care settings can seem expensive compared to operating out of one or two hubs with central prescribers and workers. 'Payment by results' targets, based on numbers completing and being discharged from OST, can also work against shared care with a perception that fewer complete treatment in primary care.

Given this, why am I so passionate that shared care should continue? Most of the people I see who are on OST are incredibly complex – not so much from their drug use but as an ageing cohort with an array of physical and mental health problems. Many of these such as COPD, coronary heart disease, hepatitis C, renal failure, depression, anxiety and PTSD are chronic conditions that need long term support and management in a primary care setting. Engagement with treatment for these conditions can be erratic and by silo-ing off the OST into a specialist service, I worry that our ability to treat these people will be severely compromised.

If our aim is to provide holistic care and improve the lives of those affected by substance use then we need to commission services that deliver health, OST and recovery as a single package. Until then having an option for shared care treatment built into local provision at least gives the opportunity to some. It would be a sad day for me if, at the end of my career in general practice, shared care for people who use drugs had dwindled back to the minority interest it was when I first started out.

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

CLINICAL EYE



STRENGTH IN NUMBERS

Could the problem of recruiting and retaining good nurses be solved by better networking opportunities? **Ishbel Straker** makes the case

In the last couple of months, I have attended some really interesting conferences on addiction. I have had the privilege of spending time with colleagues in the field – consultants, doctors, psychologists, pharmacists, and a smattering of nurses. I came away from these learning and networking opportunities questioning where are all the nurses?

'I challenge nurses and organisations... to encourage attendance at addiction conferences and be inspired!'

Some weeks before these dates, I met with a nurse whose light had started to fade. They had come to me because they felt a dwindling lack of passion for their vocation and hoped for it to be reignited. We spent time together, but whatever came from our meeting feels slightly irrelevant if we as nurses are not taking care of our passion and giving ourselves the time and space to allow it to continue to burn.

I really do feel a step towards this is networking and seizing opportunities to meet with colleagues in the field. So the question I've been asking myself is why aren't nurses attending these functions – and my two guesses are workload and organisational opportunities.

If nurses are carrying huge caseloads of complex clients then I appreciate it may not feel like a priority to travel across the country to attend a conference – but I would say that it needs to be made a priority. I also understand that there are certain staff that naturally attend conferences, and I would suggest that organisations need to look at this and alter the focus so others get the chance.

I cannot stress enough the need for nurses to expand on their learning, meet other nurses with a passion for the field, and feel valued by their employer. I guarantee that when services make a point of doing this for their nurses they will see a cultural change within the workforce, including better retention.

Not only is it inspiring to talk to others who are going through the same issues as you, but it encourages best practice and gives an opportunity to shout about it.

So, I challenge nurses and organisations over the next six months to encourage attendance at addiction conferences and be inspired! I hope to see you there!

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

DRINK AND DRUGS NEWS – WIDER HEALTH SERIES

DDN

ALCOHOL AND HEALTH

We all know that alcohol is linked to health problems; however, the range and scale of those harms is far wider than many of us think. In particular, drinking very heavily brings with it a number of serious physical risks. This special supplement, which Alcohol Research UK is proud to be sponsoring, provides a clear and detailed overview of those risks, as well as advice for people likely to encounter such problems in their day-to-day work.

As this supplement shows, heavy drinking can cause more than liver damage. Its impact on mental health, hypertension, and cancer risk are only now becoming widely recognised. The revised 'low risk' guidelines of 14 units per week for men and women reflect this growing awareness and are based on a comprehensive analysis of the full range of conditions associated with alcohol consumption. Of course, many people reading this supplement will be dealing with individuals drinking at far higher levels than those set out in the guidelines, and here the risks become very significant. However, the signs of harm are not always obvious, which is why a guide such as this is so important.

Understanding and awareness are key. Non-specialists can't be expected to provide detailed diagnoses, which is why one of the most important messages from this supplement is to get people to check in with their GP. However, knowing what some of the symptoms look like, and having a sense of what kinds of questions to ask, is invaluable. As with all things, early intervention is essential to preventing potentially tragic consequences down the line. Therefore, the advice contained here will be of enormous help to anyone working with individuals facing health risks from their drinking and, of course, to those individuals themselves.

Dr James Nicholls, director of research and policy development, Alcohol Research UK

Supported by

ALCOHOL RESEARCH UK

Alcohol Research UK and Alcohol Concern merged in April 2017 to form a major independent national charity, working to reduce the harms caused by alcohol. For more information visit: *www.alcoholresearchuk.org* and *www.alcoholconcern.org.uk*

DYING FOR A DRINK

AN OVERVIEW OF THE DAMAGE DONE

The annual number of 'alcohol-specific' deaths in the UK currently stands at well over 7,000, while alcohol-related hospital admissions number more than a million. Alcohol may have become ingrained in our society but, clearly, it is a far from benign substance

Alcohol has been consumed by humans for thousands of years, and many people use it responsibly and without significant adverse effects. However, it is also an addictive psychoactive substance. According to the World Health Organization (WHO), alcohol consumption is a 'causal factor in more than 200 disease and injury conditions'.

The UK government's revised guidelines for alcohol consumption, published in January 2016, state that 'drinking any level of alcohol increases the risk of a range of cancers' and recommend that men and women consume no more than 14 units of alcohol per week. A major international study published in *The Lancet* in April 2018 found the 'minimum mortality risk' to be around or above 100g of alcohol per week, or 12.5 UK units.

According to the latest figures from the Office for National Statistics (ONS) there were 7,327 'alcohol-specific' deaths in the UK in 2016, and while the death rate has remained unchanged for around three years it is still higher than 15 years ago. Using a 'broad measure' for alcohol-related hospital admissions – where an alcohol-related disease, injury or condition was either the primary reason for admission or a secondary diagnosis – there were an estimated 1.1m admissions in 2015-16.

In addition to the potentially serious acute effects of drinking a large quantity of alcohol on a single occasion, such as accidents, injury or alcohol poisoning, prolonged alcohol consumption can lead to a wide range of physical and mental ill health conditions, and can seriously damage many of the body's organs.

LIVER AND PANCREAS

As the human body metabolises most alcohol in the liver, this is the organ that is particularly at risk from alcohol consumption. Heavy drinking can lead to alcoholic fatty liver and liver inflammation, the scarring from which can cause cirrhosis and stop the organ from functioning properly. As the liver is a resilient organ, however, often no symptoms will manifest until the damage is at an advanced stage. Most cases of liver cancer are also associated with cirrhosis.

Heavy drinking can also cause the pancreas to become inflamed, a condition known as pancreatitis. Drinking too much alcohol can be a cause of both acute – short-term – and chronic pancreatitis, which is usually caused by years of excess alcohol consumption.

HYPERTENSION

Drinking too much alcohol is a cause of hypertension (high blood pressure), which is a risk factor for heart attacks, heart disease and heart failure, stroke, aneurysms, kidney disease and other conditions.

CANCER

Alcohol is also a risk factor for a range of cancers – as well as cancer of the liver these include cancers of the bowel, breast, larynx, mouth, oesophagus and throat. The body converts alcohol into acetaldehyde, which damages DNA and inhibits the ability of cells to repair themselves. Alcohol also increases the body's levels of hormones such as oestrogen – which have an effect on cell division – and makes it easier for the mouth and throat to absorb the carcinogenic chemicals in cigarettes.

MENTAL HEALTH

Alcohol is a depressant, which means that in the short term it can help to relieve stress and relax inhibitions, the latter making it appealing to some people with social anxiety issues. Regular drinking, however, can increase both anxiety and depression, meaning that people who drink as a form of self-medication can become trapped in a vicious circle. 'Alcohol affects the chemistry of the brain, increasing the risk of depression,' says the Royal College of Psychiatrists, while the anxiety that can accompany the physical symptoms of an alcohol hangover can lead people to drink more to feel 'normal' again – and so risk developing both mental health problems and alcohol dependency. Heavy drinking also increases the risk of self-harm or suicide, while dependent drinkers can be more prone to psychosis.

OLDER DRINKERS

While issues such as loneliness, retirement and bereavement mean older people may be more likely to drink at unhealthy levels, physiological changes also mean that alcohol can have a more detrimental effect

The UK has an aging population and much has been written about the habits of members of the 'baby boomer' generations, many of whom have grown up in a culture of heavy drinking. People aged 55-64 are currently the most likely to be drinking at 'higher' or 'increasing' risk levels, and are likely to continue these habits into older age. Of the 'alcohol-specific' deaths in the UK in 2016, most male deaths were in the 60-64 age range and most female deaths in the 55-59 age range. The alcohol-related death rate among men aged 70-74, meanwhile, has increased by around 50 per cent since 2001.

Retirement, boredom, bereavement, isolation and loneliness can all mean that older people may be likely to develop problematic drinking habits, but as people get older their bodies also start to process alcohol more slowly. This means that the effects can be more pronounced, and overall tolerance will be lower. As people age, the ratio of body water to fat decreases meaning there is less water to dilute the alcohol consumed, as well as decreased flow of blood to the liver and decreased liver enzyme efficiency. Slower reactions mean that older people are also at more risk of injuring themselves in alcohol-related falls or other accidents.

OVERWEIGHT AND OBESITY

One gram of alcohol contains seven calories, which means that a single UK unit contains 56 calories – as alcohol has no nutritional value these are known as 'empty calories'. While many alcoholic drinks are highly calorific, public awareness remains low, which is why some health organisations have been campaigning for compulsory calorie information on alcohol labelling – one pint of 4 per cent ABV beer or a 250ml glass of wine contain 180 calories each. People are also more likely to eat unhealthy, highly calorific foods while under the influence of alcohol, further increasing the likelihood of weight gain.

BRAIN DAMAGE AND DEMENTIA

Regular heavy drinking above recommended levels – particularly in the form of binge drinking – increases the risk of developing Alzheimer's disease and other common forms of dementia, such as vascular dementia. Long-term drinking at harmful levels, meanwhile, can lead to a deficiency in vitamin B1 (thiamine) which the body uses to build blood vessels in the brain – deficiency causes the vessels to leak and damage surrounding brain tissue. Alcohol-related brain damage is an umbrella term that covers a number of conditions, including 'alcoholic dementia' and Wernicke-Korsakoff's syndrome – while these are not technically types of dementia, they share symptoms such as impaired memory or thinking.

DIGESTIVE PROBLEMS

Alcohol acts as an irritant to the digestive system and increases the stomach's production of acid, which can cause inflammation of the stomach lining known as gastritis, while heavy drinking can be a cause of acid reflux and, over a prolonged period, peptic ulcers. Chronic alcohol consumption also alters the composition of bacteria in the gastrointestinal tract, reducing the number of beneficial bacteria and allowing an increase in unhealthy bacteria.

MALNUTRITION AND VITAMIN DEFICIENCY

Alcohol also reduces the pancreas's production of the digestive enzymes that help to break down carbohydrates and fat, making it harder for the body to absorb vital nutrients such as proteins and vitamins.

OSTEOPOROSIS

Alcohol's effect on the pancreas also inhibits the body's ability to absorb calcium and vitamin D, both essential for bone health. This makes heavy drinking a risk factor for osteoporosis, a condition that weakens bones and makes them more likely to break.

INFECTIOUS DISEASES

Alongside its potential damage to the liver and other organs, alcohol can also have an impact on the immune system, affecting the number, function and survival of the body's immune cells. This can put people at increased risk of contracting viral and bacterial infections – according to WHO there is a 'causal relationship' between harmful drinking and 'incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS'. Alcohol-related liver damage also increases the body's susceptibility to bacterial infection.

ALCOHOL POISONING

Alcohol poisoning is a potentially fatal condition that occurs when a person drinks a dangerous quantity of alcohol, usually over a short period such as in binge drinking episodes. In severe cases people can choke on, or inhale, their vomit, or have seizures or heart attacks.

OTHER ISSUES

To this wide range of physical and mental health conditions can be added acute incidents such as alcohol-related injuries and accidents, including those caused by drink driving. Alcohol is also a significant contributory factor to domestic violence and violent crime generally – the Annual Crime Survey for England and Wales records that almost half of the victims of violent incidents perceived the offenders to be under the influence of alcohol.

Alcohol misuse can also lead to financial, employment and housing problems as well as relationship difficulties and parenting issues – it is estimated that around 200,000 children in England are currently living with a dependent drinker.

REACTIONS WITH OTHER DRUGS

Mixing drug use and alcohol consumption is common, but alcohol can react with other substances – legal or illegal – in unpredictable and potentially harmful ways

CANNABIS

Combining cannabis use with alcohol can magnify the effects of THC, the drug's main psychoactive ingredient, causing lethargy, dizziness, impaired coordination and anxiety.

HEROIN

Using alcohol with heroin increases the respiratory depression effects of the latter, which places the user at greater risk of overdose or respiratory failure. Many fatal heroin overdoses also involve alcohol.

COCAINE AND AMPHETAMINES

Cocaine use offsets the depressive effects of alcohol, which allows people to stay awake and alert for longer while drinking. They are therefore more likely to drink larger amounts and lose track of their consumption. Combining cocaine and alcohol also causes the liver to produce a toxic substance called cocaethylene, which takes longer to process than alcohol alone and is more harmful than either substance in isolation. Drinking and taking cocaine at the same time can cause arrhythmias – irregular heartbeat – and other heart problems, as well as stroke, seizures, anxiety, paranoia and aggressive behaviour.

As with cocaine, amphetamines increase the amount of alcohol needed to feel its effects, meaning people are likely to drink larger amounts over longer periods. With both cocaine and amphetamine, the severe 'come down' mixed with an alcohol hangover can cause depression and anxiety, while a lengthy drinking session fuelled by either drug increases the risk of alcohol poisoning, blackouts and accidents.

BENZODIAZEPINES AND OTHER SEDATIVES

Alcohol and sedatives both act as a central nervous system depressant, slowing brain activity. Using them together can cause confusion and impaired judgement, dizziness, severe drowsiness and lethargy, as well as problems with coordination and memory.

GHB/GBL

These drugs again combine with alcohol as an extreme central nervous system depressant, impairing coordination and reactions.

MDMA

Alcohol and MDMA both increase dehydration, a factor in most MDMA-related deaths. Combining the two can also put extra strain on the kidneys and liver.

NEW PSYCHOACTIVE SUBSTANCES (NPS)

NPS is a broad term used to cover a range of substances – the best known of which are synthetic cannabinoids such as 'spice' or cathinone stimulants like mephedrone – that were previously known as 'legal highs'. Little is known of the potential long-term effects – and, in some cases, even the ingredients – of many NPS, so combining them with alcohol increases the risk of unpredictable and potentially dangerous outcomes.

ON THE LOOKOUT

IDENTIFYING POTENTIAL PROBLEMS

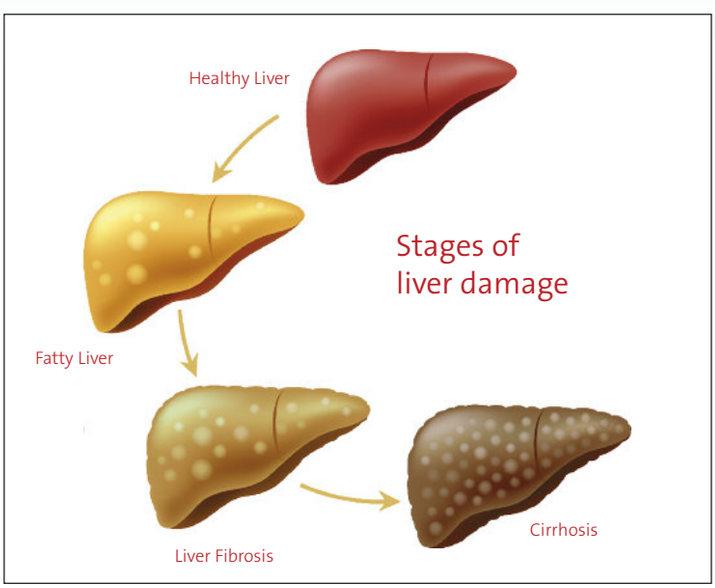
In this section we look at when substance misuse staff should recommend that clients see a GP to discuss their symptoms, as well as when wider health professionals should think about referring patients to specialist alcohol services

SYMPTOMS OF ALCOHOL-RELATED CONDITIONS

If a client reports – or you notice – symptoms of any of these conditions, you should urge them to visit a GP immediately

ALCOHOLIC LIVER DISEASE

Alcohol-related liver disease often will not show any symptoms – even with cirrhosis – until the very late stages when the liver has already undergone severe damage. At this point the symptoms can include a yellowing of the skin and eyes (jaundice), weight loss, nausea, loss of appetite, feeling tired and weak, bruising easily, itchy skin, swollen ankles, blood in stools or vomiting blood.



CHRONIC PANCREATITIS

The most common symptom is recurrent stomach pain or burning sensation. In later stages, the pain may become constant, and people may also experience nausea, loss of appetite, weight loss and jaundice. Damage to the pancreas can also lead to diabetes, symptoms of which include excessive thirst, tiredness and urinating more frequently.

HYPERTENSION AND CORONARY HEART DISEASE

Hypertension (high blood pressure) itself rarely causes any noticeable symptoms. However, it is a risk factor for a range of other conditions, including coronary heart disease (CHD), the main symptom of which is angina, or chest pain. This can range from mild discomfort to a painful feeling of extreme tightness, while other symptoms of CHD include breathlessness and heart palpitations.

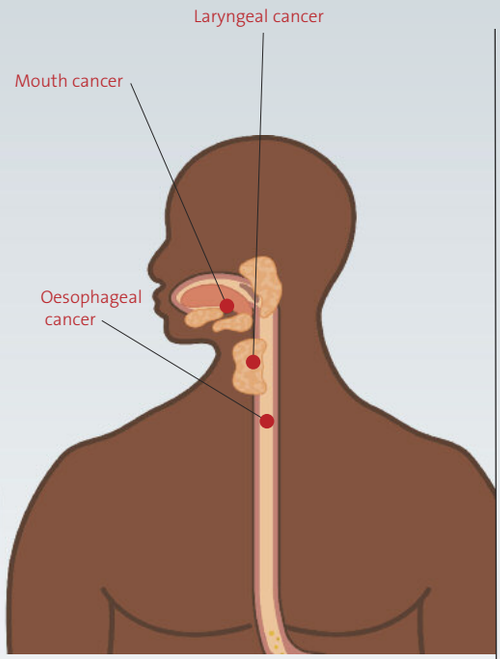
FOR WIDER HEALTH PROFESSIONALS
WHEN TO REFER PEOPLE TO SPECIALIST ALCOHOL TREATMENT

The World Health Organization has produced an alcohol use disorders identification test (AUDIT) for use by health professionals to assess a client's risk level for alcohol harm. This has been adopted by Public Health England for use in the UK

The AUDIT – which is available to download along with guidance notes – consists of ten questions with a scoring system of zero to four points for each. It recommends that those scoring between eight and 19 be given brief advice to encourage lower consumption, while professionals should consider referring anyone scoring 20 or above to specialist harm assessment. There is also a shorter version called AUDIT-C, available for use in primary care, emergency departments and other settings.

Many guidance documents stress the importance of promoting self-belief and the idea that change is possible as a way of motivating people to access help. The Alcohol Concern Blue Light Project Manual contains a specific section on how to build motivation and develop self-belief, as well as a quick guide to identifying possible symptoms of more serious conditions.

Many dependent and higher-risk drinkers will also experience mental health problems, and both NICE and Public Health England have produced useful guides to dual diagnosis care frameworks.



CANCERS

The main symptoms of alcohol-related cancers are:

BOWEL CANCER
Rectal bleeding or blood in stools; changes in bowel habits; unexpected weight loss; abdominal pain.

BREAST CANCER
A lump in the breast; changes in the size, shape or feel of the breast; changes in the skin on the breast.

LARYNGEAL CANCER
Hoarseness that lasts more than three weeks; difficulty swallowing; weight loss.

MOUTH CANCER
Pain in the mouth, or an ulcer that won't heal; unusual white or red patches in the mouth; difficulty swallowing.

OESOPHAGEAL CANCER
Persistent indigestion or heartburn; difficulty swallowing; persistent cough; pain in the throat; weight loss.

ALCOHOL-RELATED BRAIN DAMAGE/ WERNICKE-KORSAKOFF'S SYNDROME

Symptoms include memory loss, erratic behaviour, poor judgement and difficulties with familiar tasks or processing new information. The symptoms can often be mistaken for intoxication.

With Wernicke-Korsakoff's syndrome the symptoms are similar but usually appear much more quickly and with more severity. Wernicke-Korsakoff's syndrome is made up of Wernicke's Encephalopathy and Korsakoff's Psychosis – symptoms of the former include confusion and disorientation, blurred vision, poor balance and numbness in the hands and feet. Again, people will often appear drunk even if they haven't been drinking. Symptoms of Korsakoff's Psychosis include memory loss, confusion and apathy.

STOMACH ULCERS

The symptoms of peptic ulcers include persistent indigestion, heartburn, abdominal pain and bloating.

MALNUTRITION

Symptoms include unintended weight loss, weakness and lethargy, lack of appetite, depression and wounds taking a long time to heal.

INFECTIOUS DISEASES

Symptoms of tuberculosis (TB) include fever, night sweats, weight loss and fatigue. If the infection is in the lungs (pulmonary TB) symptoms will include breathlessness and a persistent cough, which may be bloody.

ALCOHOL POISONING

Signs of alcohol poisoning can include stupor, fits, loss of consciousness and inability to wake up, confusion, slow or irregular breathing, pale or blue-tinged skin and hypothermia.

FOR STAFF IN ALCOHOL SERVICES
WHEN TO REFER YOUR CLIENTS TO A GP

What to look out for, and when to urge people to seek help

Generally, any clients in specialist substance misuse treatment should be strongly encouraged to visit a GP – and dentist – for check-ups. Not only can this help in the early identification of any health issues but it can also act as a motivator for behaviour change, although some clients may need support in attending these appointments.

However, alcohol treatment staff are likely to see many of their clients far more frequently than these clients see a GP, and there are questions that staff without formal medical qualifications can ask to help identify key signs of common problems experienced by heavy drinkers. They can also help raise awareness of these issues among clients and encourage them to be on the lookout for potential symptoms. It is often a good idea to begin with an open-ended enquiry such as 'Have you had any health problems recently?' before asking specific questions.

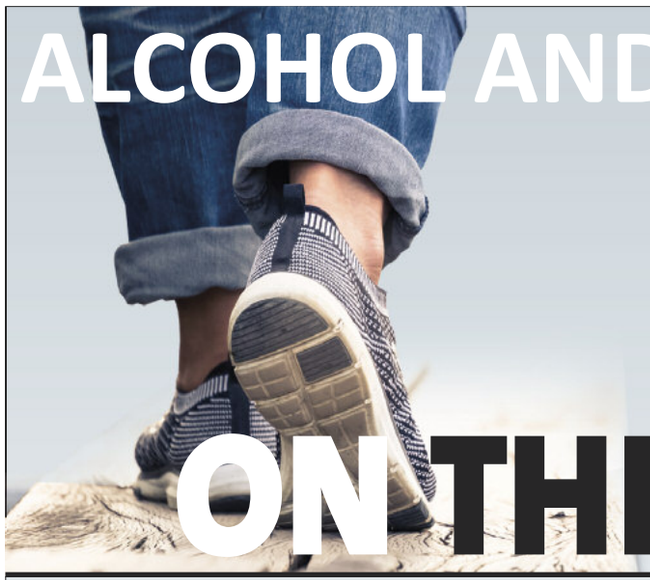
Some general questions that might identify potentially serious health issues include asking if clients ever have sensations of numbness or pins and needles in their hands and feet, if they ever have fits or seizures, or if they feel unsteady or experience double vision, confusion or problems with short-term memory. Staff could also ask if they have difficulty swallowing solid food, have a mouth ulcer that won't heal or if their stools have become looser than normal or contain blood.

Staff could also enquire if their clients have experienced severe stomach pains, or hoarseness or voice changes that have lasted more than three weeks. Finally, clients could be asked if they have irregular heartbeats or feel their hearts race or skip beats to the extent that it makes them feel unwell. Anyone answering yes to any of these questions should be advised to see a GP as a matter of urgency.

More generally, very heavy drinkers should also be encouraged to have blood pressure checks at least once a year and a fibroscan (ultrasound) liver test every two years – this can reveal liver damage that won't be identified by blood tests alone. Female clients over 50 should also be encouraged to attend breast screening and to regularly perform self-checks for signs of breast cancer.

There are, however, certain circumstances in which staff should either call an ambulance or take a client immediately to A&E. These are when a client collapses, has fits or becomes unconscious, or if they show signs of agitation, severe confusion, hallucinations or fever consistent with alcohol withdrawal. The same applies if the whites of their eyes or skin turn yellow – which may indicate liver failure – or if they experience potential heart attack symptoms such as painful heaviness or tightness in the chest or arms, neck, jaw, back or stomach.

Overall, however, the golden rule is that clients should be encouraged to visit their GP for check-ups as a matter of course so that they can be seen by a qualified medical professional.



ON THE RIGHT PATH

NAVIGATING A WAY FORWARD

In this section we look at the key partners in referral pathways as well as the potential barriers to be overcome, and hear from organisations that have adopted a particularly successful or innovative approach

The referral chain for alcohol-related harm encompasses a wide range of healthcare and other bodies. Within health services it can include primary and emergency care settings, as well as hospital wards, outpatient departments, ambulance services, sexual health clinics, dentist surgeries, occupational health, pharmacies and antenatal clinics. Key non-health partners, meanwhile, include social services and social care, criminal justice and probation services, higher education, housing and voluntary sector organisations.

According to NICE guidelines, NHS professionals should be carrying out alcohol screening as a routine part of their practice – such as during new patient registrations, medicine reviews or screening for other conditions – with particular focus placed on groups at increased risk of alcohol-related harm. These include anyone presenting with relevant physical or mental conditions such as liver problems, high blood pressure, anxiety or depression.

Professionals should also focus on people who frequently present with injuries or regularly attend sexual health clinics, while non-NHS staff – such as those in social services, the voluntary sector or criminal justice – should also focus on people at risk of assault or self-harm.

The NICE guidelines stress the importance of not simply offering brief advice when someone seems to be alcohol-dependent. Anyone showing signs of moderate or severe dependence should be referred to specialist treatment, along with anyone displaying signs of severe alcohol-related impairment or who has alcohol-related mental health issues or liver disease. The guidelines also advise using professional judgement to potentially revise down AUDIT scores in the case of certain groups, such as older people, teenagers or women who are planning to become pregnant, stressing that offering an intervention is 'less likely to cause harm than failing to act where there are concerns'.

Attending alcohol treatment may also be a conditional requirement of some community sentences in the criminal justice system, while clients can also be referred via housing bodies, particularly in the 'Housing First' model. This originated in the US but has been increasingly adopted in the UK, and uses provision of independent, 'condition-free' housing as a key means of moving people with complex needs away from homelessness and towards recovery from conditions including alcohol dependence.

> "workers in social services, the voluntary sector or criminal justice – should also focus on people at risk of assault or self-harm

> "NHS professionals should be carrying out alcohol screening as a routine part of their practice

One common, and significant, barrier to referral is reluctance on the part of the client – an understandable response, as many alcohol-dependent people will be in denial about the extent of their problem and find it a difficult thing to face up to, particularly considering the levels of stigma that still exist. Fear and confusion around what alcohol treatment may entail will deter many, alongside

ONE STEP AT A TIME

Case study 1

Cutting down intake gradually can be the only approach for those used to living with alcohol problems

Equinox provide services to people affected by drugs, alcohol and mental health issues, including street outreach. They came across Phil, a 41-year-old man, who had been living in a supported hostel for the past 18 months. He had a long history of alcohol misuse, legal high use, homelessness and poor physical and mental health, and had made little progress in tackling his problems.

An Equinox worker made a plan to support Phil in reducing his drinking to a level that was appropriate for him, and arranged for him to attend mutual aid support within the city. He was introduced to the idea of a daily drink diary, and this was reviewed at the end of every week, then fortnight – and showed a marked reduction in his drinking. This has meant that he has been able to attend health appointments with doctors, as there were issues regarding his poor eating habits, anxiety and depression.

He has begun to attend Springboard support groups and also attend meetings with his hostel key worker, who has been part of his support plan from the start. His legal high use has decreased and he reports feeling much better in key work sessions. He is talking about gaining life skills and doing voluntary work so he can move into band-three accommodation – the next step towards independence.

HOLISTIC SUPPORT

Case study 2

Linking to others in recovery, as well as support services, can be a vital boost to letting go of dependence on alcohol

Phoenix work with a range of partners to deliver holistic support through supported housing, peer-led recovery houses, and independent flats. 'Community as method' underpins their approach: living with people who are like-minded and with similar goals can be inspirational, while diversionary activities such as volunteering or peer mentoring can help to fill the void left by addiction.

Mark came to Phoenix after completing treatment at one of their rehabs. A drinker for many years, he had a history of homelessness and was living in a hostel before engaging with treatment. Initially he found the transition to abstinent living difficult and experienced lapses.

His support worker met with him to talk about the pros and cons of continuing to drink, drew up an agreement and action plan, and used long-standing partnerships to link him into additional support. This included fast-track referral to aftercare provision, involving one-to-ones and group work. In addition to daily check-ins with his key worker, focusing on triggers and coping strategies, Mark benefited from living with others at various stages of their recovery journey and discussing ways of keeping on track.

Mark agreed to more rigorous monitoring in the form of regular and random breathalysing, and was supported to make use of volunteering opportunities. While he did lapse a couple of times, by using an asset-based approach focused on increasing recovery capital he gradually reduced his drinking episodes, and after a 12-month period of abstinence is now working part time to support others in recovery. He will be moving into his own accommodation in the next few months.

concern about potential employment implications and reluctance to be labelled an 'addict' or 'alcoholic'. Some studies have also identified peer influence as a barrier to accessing help – 'lots of my friends drink as much or more than me, so how can I have a problem?'

Empathy and encouragement from professionals is key in these situations, and NICE recommends an extended brief intervention as a useful next step, in the form of a 20-30 minute motivational session with follow-up sessions if necessary.

> "guidelines also advise using professional judgement to potentially revise down AUDIT scores in the case of certain groups

Other common barriers to an effective pathway can include poor joint working or 'buck passing' between agencies, discriminatory attitudes on the part of wider health professionals – possibly as a result of bad experiences with a small number of patients – and lack of family support or 'recovery capital' for clients. Ongoing budget constraints, meanwhile, can mean lack of suitable local support or long waiting lists where it does exist.

While NICE stresses that health services and local authorities should prioritise alcohol as an 'invest to save' measure and that commissioners ensure that 'at least one in seven dependent drinkers can get treatment locally', decreasing funds and competing priorities mean that alcohol treatment will often lose out at local level. Last year, widely reported analysis by The King's Fund found that public health spending by local councils in 2017-18 would be 5 per cent below the 2013-14 level, representing an £85m cut for services such as alcohol, drugs and sexual health, and with ongoing reductions planned until at least the end of the decade.

> "empathy and encouragement from professionals is key

When it comes to dual diagnosis – clients with co-existing alcohol and mental health issues – one common barrier to effective joint working is people being refused access to mental health services unless they've been abstinent for a set period. This is often coupled with a distrust of services on the part of clients, frequently the result of being passed between multiple agencies without receiving appropriate support, all of which can put dual diagnosis clients at higher risk of relapse.

Across all pathways, clarity and consistency – for example, standardised assessments – are vital, along with active engagement and encouragement from well-trained, non-judgmental staff.

AWAY FROM CRISIS

Case study 3

An innovative form of outreach can provide the bridge to stability for those turning to alcohol to cope

The Arch integrated treatment system offers support to those living in Hillingdon, London. It is led by CNWL NHS Foundation Trust in partnership with Blenheim, WDP and Build on Belief.

The team's Emerald Pathway is designed to work with older individuals, often with restricted mobility, who are using alcohol problematically. The pathway is designed to specifically target service users who might otherwise not access treatment at building-based services, and prevent potentially harmful and escalating alcohol use.

The pathway was developed in response to the need to reach out to people who weren't accessing Arch's services, but who had been recognised – particularly via A&E admissions – as needing an intervention around their alcohol use.

The experience of a recent service user demonstrates the pathway's impact. Martin's drinking had increased after his wife died, and he was struggling to cope. He was referred via Arch's alcohol liaison worker, based in A&E, after his excessive alcohol consumption had led to several hazardous falls at home, leaving his daughter concerned for his wellbeing.

On receiving the referral, the outreach team went to visit Martin at home and talk further about his drinking and his goals. He was given a drinks diary and information about the impact of his drinking on his health. The team engaged with his family and offered them some carers' support, as well as looking for community services that he could access as a way of addressing the loneliness he felt.

Martin was seen for four sessions at home and was able to gradually reduce his drinking, replacing his evening wine with a non-alcoholic supplement. He now only drinks alcohol on occasion, and is incredibly proud of the progress he has achieved. He was positively discharged from Arch, and has subsequently taken his recovery journey one step further by joining a community group coffee morning for those over the age of 50.

ALCOHOL AND HEALTH

> “The referral chain for alcohol-related harm encompasses a wide range of healthcare and other bodies. Within health services it can include primary and emergency care settings... Key non-health partners, meanwhile, include social services and social care, criminal justice and probation services, higher education, housing and voluntary sector organisations.

SOURCES AND CONTACTS

PAGES 2-3: *OVERVIEW*

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All in the mind: meeting the challenge of alcohol-related brain damage.
www.alcoholconcern.org.uk/all-in-the-mind

Alzheimer's Society
www.alzheimers.org.uk

NHS Choices
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Royal College of Psychiatrists
Alcohol and depression factsheet.
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Alcohol Concern, Blue Light Project
Working with change-resistant drinkers: the project manual.
www.alcoholconcern.org.uk/Handlers/Download.ashx?IDMF=8ec66a11-104f-4f02-aed8-892e23522c14

Department of Health
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National Institute for Health and Care Excellence (NICE)
Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings.
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NHS Choices
www.nhs.uk

Public Health England (PHE)
Alcohol use disorders identification test (AUDIT) and other alcohol use screening tests and guidance.
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NICE
Alcohol use disorders: diagnosis and management – quality standard QS11.
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The King's Fund
Chickens coming home to roost: local government public health budgets for 2018/18.
www.kingsfund.org.uk/blog/2017/07/local-government-public-health-budgets-2017-18

USEFUL CONTACTS

Alcohol Research UK/Alcohol Concern
www.alcoholresearchuk.org and www.alcoholconcern.org.uk

NICE
www.nice.org.uk

Public Health England
www.gov.uk/government/organisations/public-health-england

Addaction
www.addaction.org.uk

Alcoholics Anonymous (AA)
https://www.alcoholics-anonymous.org.uk

Blenheim CDP (incorporating **HAGA**)
www.blenheimcdp.org.uk

Change, Grow, Live (CGL)
www.changegrowlive.org

Equinox
www.equinoxcare.org.uk

Phoenix Futures
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Turning Point
www.turning-point.co.uk

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www.adfam.org.uk

National Association for Children of Alcoholics
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NHSSMPA (for NHS treatment providers)
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SMMGP (supports good treatment practice)
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Drink Wise Age Well
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www.drinkanddrugsnews.com

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DRAWING

Does continuing professional development (CPD) have a purpose for volunteers and people without professional qualifications? Absolutely, says **Kate Halliday**, who explains how to get started

WHAT IS CPD?

Continuing professional development (CPD) describes the process of documenting the skills, knowledge and experience that we gain as we work, and how we apply this learning. This can include formal learning (a training course for example) and informal learning (observing a colleague or taking part in a meeting). The important aspect of CPD is that the learning is recorded somehow. For many this may be a physical folder of evidence, though increasingly CPD is recorded electronically.

WHAT IS THE POINT OF CPD?

Recording what you learn, how you learn it, and how you apply it, can help you develop as a practitioner and improve your skills and knowledge, providing a better service for clients. This in turn helps you develop your career, and it helps your employer deliver services.

WHAT IS THE DIFFERENCE BETWEEN CPD AND TRAINING?

The terms 'training' and 'CPD' are often used interchangeably, but they are different. On the whole, training describes a linear and formal process with the aim of learning a specific skill or area of knowledge. Development is often informal and describes the ability to move from basic 'know how' to more advanced and complex application of skills and knowledge. So you may receive training on how to complete an assessment. You can evidence development when you complete a complex assessment, perhaps with the support of a colleague.

IS CPD ONLY IMPORTANT FOR PEOPLE WITH PROFESSIONAL QUALIFICATIONS?

No! It is true that many professional bodies (such as the Health and Care Professional Council) require their members to have completed a specified number of hours of CPD to remain a member or become accredited. But there is great value in non-qualified practitioners, including volunteers, keeping a log of their CPD. There are a number of ways this can help:

- You can begin to identify the areas you have knowledge, skills and experience in, and identify the areas you need to learn more about. If you are a volunteer who is interested in getting employment in the field, then this can be especially useful in helping gain the experience and learning you need to get a job. I have seen people use their CPD record effectively in the interview process by letting employers know that they record and reflect on their learning, and are aware of both their strengths and the areas in which they would like to develop.
- It can help with confidence: setting goals and achieving them feels good! And it can help us get to where we want to go.
- It can help us understand how we learn; we all have different learning styles. Some of us need a bit of time away from the workplace to read and reflect, and others like discussions and learning on the job. If you understand the best way for you to learn, you may be able to tailor future learning goals to your style.

ON EXPERIENCE

- It can help us become reflective practitioners. Sometimes making mistakes can be a great way of learning (even if it is painful at the time!). It is good to be able to process both things that have gone well, and also things that have not worked.
- CPD makes us better practitioners, providing a better service to our clients.

HOW DO I START?

Many professionals will have a format that they will follow as part of their membership of a professional body. Some workplaces will also have templates that can support recording of CPD. But you do not have to have a formal template to get started. As long as you follow these steps you can begin your CPD record:

1 RECORD YOUR LEARNING

Think about any learning experiences you have had in the last year, and provide a written record that reviews and reflects upon their impact, including what and how you learned from them. This could include formal training, or informal learning which may be gained from:

- observing or discussing cases with colleagues
- attending team meetings
- reading articles, books, or blogs
- learning that has taken place in supervision or mentoring
- learning that has taken place if you have taken up a new role or activity
- learning from a situation that has not gone according to plan

2 RECORD WHERE YOU WOULD LIKE TO BE

Think about the direction you would like to take over the next one, three and five years. This could be about gaining employment if you are a volunteer, getting a promotion, developing a specialism, or deepening a skill in your current role.

3 RECORD WHAT YOU HAVE TO DO TO GET THERE

This may be taking on some formal training, or gaining more experience at work in a specific area. Or it may be as simple as discussing the next steps in supervision.

4 REVIEW YOUR PROGRESS

Set a date for when you will review the goals you have set yourself. This could be every month, three months, six months or every year. It will often depend upon what stage you are at in your working life.

SUMMARY: KEY FEATURES OF CPD

- **DRIVEN BY YOU (SELF DIRECTED) AND NOT YOUR EMPLOYER**
- **RECORDED – ELECTRONICALLY AND/OR IN A PAPER FOLDER**
- **INCLUDE LEARNING GAINED FROM FORMAL TRAINING AND FROM INFORMAL EXPERIENCES**
- **BE REFLECTIVE – NOT SIMPLY A LIST OF TRAINING COURSES YOU HAVE COMPLETED/ MEETINGS YOU HAVE ATTENDED, BUT DESCRIBE WHAT YOU HAVE LEARNED, AND HOW YOU WILL APPLY IT IN THE FUTURE**
- **FOCUS ON THE LEARNING PROCESS AND NOT SIMPLY THE KNOWLEDGE, SKILLS AND EXPERIENCE THAT YOU HAVE**
- **IDENTIFY GAPS IN YOUR SKILLS, KNOWLEDGE AND EXPERIENCE**
- **IDENTIFY FUTURE GOALS AND HOW YOU COULD ACHIEVE THEM**
- **INCLUDE REVIEWS OF YOUR GOALS**

Kate Halliday is FDAP/SMMGP interim executive director

‘My learning log landed me a new job’

Documenting experience makes you a serious bet for employers, says Jenny

Having been in recovery for a while, I began to volunteer at my local services. I started by welcoming people in the waiting area and signposting them to what services were around, depending on what they wanted, and generally encouraging them into recovery and giving them support. After a few months I began to get involved in delivering groups – nerve wracking at first but I loved it.

My supervisor and mentor always encouraged me to keep a log of what I had learned – whether it was from a training course or learning from others (or from my own mistakes!). During supervision I talked about how I wanted to become a drug and alcohol recovery worker, and my supervisor encouraged me to put this in my learning log as a goal and to take some basic qualifications (maths and English) to make me more employable. And they also began to give me a bit more responsibility at work. I got training, shadowed people and began to deliver needle exchange.

> ‘...they could see that I had goals and I was meeting them.’

When a recovery worker job came up in another service nearby, my log of learning really helped me fill in the application form – not just my qualifications and training, but also my personal statement, my skills, knowledge and experience and what I still wanted to learn. If I had not been keeping a log I don’t know how I would have begun to fill in the application form! I was really pleased to get an interview. I took my learning log along to the interview and talked about it and showed it to the panel.

I can’t tell you how pleased I was to get the job and the feedback I got was that my learning log had helped – they could see that I had goals and I was meeting them, and I wanted to give the best service I could to the clients. I have been a recovery worker for a year now and am still keeping a learning log. My next goal is to get a promotion – although I think I still have a lot of learning to do before this happens!

I would encourage anyone to log your learning – whether you are a volunteer or working in a service. It helps you improve your work with clients, making you better at what you do. It helps you meet your goals – and it helps show that you are serious about your role, making you a good bet for employers if you want to work in recovery services or get a promotion.

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.


COVER STORY

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 Durjava shares her findings

'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.'

'Why we would want to copy models from a country with the highest number of prisoners (more than 2m) and an insatiable appetite for locking up ethnic minorities is baffling.'

DOWNWARD SPIRAL

I applaud Ms Durjava's sensitive and respectful study of heroin users in prison (*DDN*, May, page 6). Government drug strategies invariably talk negatively about drug use and base their strategies accordingly – on the crude assumption that, given plenty of stick and a bit of carrot, all users want to stop. It is refreshing to read heroin use interpreted rationally for once, as a solution rather than a problem.

The UK prison system is in free fall and heading for the very bottom, as we all well know, and in spite of all the warnings successive governments have failed to take responsibility.

There are oases of good practice here and there, but overall successive governments have been utterly failing the disadvantaged, maligned, and ever increasing population shoved out of sight behind bars. As a result, the article explains, prisons are in perpetual crisis. It is hardly surprising that their residents like taking heroin, or anything else that might help to obliterate their misery.

It does not have to be like this. In search of humane and effective alternatives, the Dutch government has been closing prisons since 2009, sometimes renting them out for use by offenders from Norway and Belgium. Our government too has looked across the water for inspiration. Their preference though has been for American business models that drive down costs and do almost nothing for resources.

Why we would want to copy models from a country with the highest number of prisoners (more than 2m) and an insatiable appetite for locking up ethnic minorities is baffling. It's a recipe for ongoing failure, and signals just how divorced from reality have become the ministers and civil servants propelling us down this miserable road.

The mandarins who peer down the wrong end of a telescope from their ivory towers before making up some new policy or other are, quite simply, clueless. Think of former justice secretary Grayling's tenure, for example, and his aim to restrict prisoners' access to books, or to sell prison training to Saudi Arabia. Thus many prisoner governors, staff, and indeed prisoners desperate for change, find themselves endlessly thwarted instead of supported by government.

Meanwhile life in prisons grinds on, at the mercy of ministers who have little or no idea what they're dealing with. Take so called drug-free wings, offering privileges to people who agree to random drug testing. As cannabis may be detectable for a month or more while opiate traces are gone in more like 24 hours, policy has created another scenario where taking heroin is the rational choice.

What hope this Brexit-obsessed government will ever get a grip?

Paul Taylor, by email

CAPITAL CRISIS

In response to Alex Boyt's piece in the April edition of *DDN* (page 12), one cannot help but recognise the absence of distinction between what can perhaps be classified as 'addiction' with a small 'a' to indicate a behaviour that includes the habitual use of psychoactive substances for recreational reasons which might have some social and personal consequences, in contradistinction to 'Addiction' with a capital 'A' to indicate chronic substance misuse that has reached a life-threatening level after following a chaotic path of personal loss and degradation that impacts family, friends and society at large.

Alex is clearly referring to 'addiction' with a small 'a' when suggesting someone in recovery being able to imbibe a beer on a warm day while neglecting to take into consideration the neuroscience of Addiction with a capital 'A' that has ascertained the fundamental requirement of a corridor of abstinence for the metabolism to realign itself towards overall stability. This, for those suffering chronic life-threatening Addiction with a capital 'A, affords an opportunity to achieve homeostatic neurochemical balance that includes the ability to keep addiction with a capital 'A' in remission by the observance of abstinence on a daily basis.

Alex also struggles with the word 'powerless' within the 12-step framework; yet this terminology is simply a paradox that proves the truth so to speak, in that once one has been able to accept their 'powerlessness' over Addiction with a capital 'A' one immediately gains the 'power' to do something about it, given that such admittance brings one out of denial which has been the unconscious dynamic driving the Addiction.

Of course Alex is being true to himself exploring his own preferences and prejudices while questioning the integrity of the 12-step programme – the efficacy of which is predicated on abstinence – although one wonders why he has to do this in a magazine of wide circulation that is read by individuals who may be in early recovery and have achieved 'power' over Addiction with a capital 'A' by means of the abstinence-based 12-step programme? What is the gain in casting doubt?

One wishes Alex well on his own journey, while perhaps suggesting he might demonstrate an attitude of acceptance for others who might not be as articulate as he is, but who nevertheless have an attitude of simple faith that abstinence-based recovery supported by the 12-step programme works as an enduringly life-saving intervention for each person individually.

John Graham, therapeutic counsellor (retired)

JUST BE HAPPY

There's lots of great things about the fellowship (*DDN*, April, page 12) that I have benefited from and it certainly guided me from a selfish crazy drug addict child to the decent adult that I am now. I learnt how to laugh and judge and meet entirely the wrong men.

I liked God for a bit but wanted my power back – the one I own to make choices based on my own critical thinking. I agree that it has inherent flaws for me, but it played a valuable part.

But it was just a part. We did it so we are entitled (after a life of beating ourselves up for being flawed) to think and feel whatever we want. And to be happy. We are awesome.

Jo Rollason, via www.drinkanddrugsnews.com

SLIGHT DIVERSION

Diverting addicts from courts to treatment. This sounds pretty good. Until we ask: 'What treatment? Where is the treatment? What is the goal of treatment?'

The current goal established for the Department of Health by psychiatric Professor Sir John Strang's 'Orange Book' and his National Addiction Centre is merely to move addicts from usage of illicit drugs to continuing daily usage for life of prescription pharmaceutical drugs.

That's not 'treatment'. It's a clever profitable takeover by the psycho-pharm fraternity of clients created by drug barons and their pushers!

Or is 'treatment' persuading addicts to move themselves into 12-step AA, NA or CA groups in the hope that their dedication will deliver a few more 'clean' former addicts back into society at no cost to the government?

The truth is that 'treatment' is the wrong approach, because little of it delivers a lasting return to the natural state of relaxed abstinence which every addict needs, wants and deserves.

What does work is addiction recovery self-help training which gives an addict the knowledge he or she needs, plus the necessary revival of responsibility which together puts the former addict back in control of their life – for life.

But because the 'Orange Book' and the National Institute for Health and Care Excellence have recently downgraded all residential rehabs as ineffective, and because addiction recovery self-help training is necessarily also residential, every approach to addiction handling which is not based on some form of non-residential substitution therapy has now been effectively negated in the minds of the ministers and officials who make government drugs policy.

Above all else, what every addict needs is true and honest knowledge and a resurrection of personal responsibility in order to get themselves back in control of their lives, and availability of these vital factors should not be deprived of government support just because their delivery happens to be residential.

E Kenneth Eckersley, CEO Addiction Recovery Training Services (ARTS)

SURVIVING AND THRIVING

Kaleidoscope at 50

'It's down to you guys that people get a chance of a new life.' Eleanor Conway pauses for a serious moment during a 'stand-up' routine that entertained guests at Kaleidoscope Project's 50-year anniversary celebration.

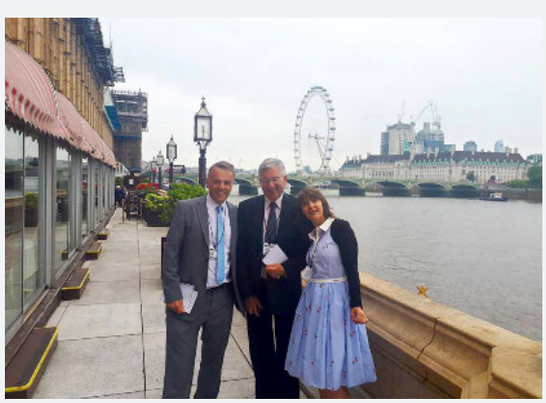
'I have huge respect for the organisation – for its values as well as its evidence-based approach,' added Annette Dale-Perera, in her speech. 'You have to keep trying, and that's what Kaleidoscope keep demonstrating. She spoke of her first visit to Kingston, where the charity was pioneering harm reduction through its needle exchange and methadone dispensing service. It was 'chaotic, busy and noisy' and 'a fantastic example of harm reduction and recovery-orientated services'. Most importantly it was a 'place of sanctuary' and 'served a population in need when others had rigid rules to exclude them.'

'Kaleidoscope has always challenged orthodoxy and provided evidence-based practice, even when this hasn't been the prevailing zeitgeist,' she said. 'You guys have made a difference to thousands of people's lives.'

'We haven't just survived, we've grown and flourished – but our commitment to harm reduction hasn't changed,' said the charity's chair Chris Freegard, while CEO Martin Blakebrough thanked the many guests who had supported them in their mission. Surviving and thriving also meant proactively working with police and crime commissioners: 'Criminal justice is as an important partner for change,' he said.

'Kaleidoscope has always challenged orthodoxy and provided evidence-based practice, even when this hasn't been the prevailing zeitgeist'

ANNETTE DALE-PERERA



BACK TO REALITY

Getting the right treatment can reverse effects of alcohol-related brain damage, says **Alyson Smith**

Alcohol-related brain damage (ARBD) refers to the damaging effects of long term alcohol consumption on the brain. Alcohol toxicity, vitamin deficiencies and disrupted blood supply to the brain can result in a range of serious conditions, including Wernicke's Encepalopathy, Korsakoff's Syndrome, alcohol-related dementia and alcohol amnestic syndrome.

It has been suggested that these disorders are best regarded as occurring on a spectrum (Jacques and Stephenson 2000). It is not the same thing as age-related dementia; ARBD occurs when a person is deficient in thiamine (vitamin B1) and if untreated can lead to memory problems and frontal lobe dysfunction (Chiang, 2002).

The impact of ARBD ranges from mild to very severe. The good news is that this need not necessarily be progressive if people can engage in cognitive rehabilitation, abstain from alcohol and maintain a good diet. While intellectual functioning appears to remain intact, memory and social functioning can be improved through targeted rehabilitation. Smith and Hillman (1999) suggest that 75 per cent of clients can expect some level of recovery, with 25 per cent making full recovery.

It is very difficult to obtain accurate prevalence figures for ARBD. However, a service for those under 65 years of age in Cheshire and the Wirral reportedly receives three new referrals per month, suggesting an annual incidence of 13.9/100,000 in those aged under 65 (Wilson quoted in Smith and Emmerson, 2015).

Research (Wilson, 2014) suggests that the experiences of people with ARBD within the healthcare system are very poor. They include a lack of diagnostic expertise, general ignorance of psychiatric, medical and nursing staff, lack of care pathways and resources and stigma. Patients can fall between services and have higher rates of morbidity and mortality.

A report from Public Health Wales (Emmerson and Smith, 2015) suggested that given the estimated prevalence of ARBD, residential rehabilitation required for this group is inadequate. In 2014, a task and finish group was set up at Brynawel Rehab to address this gap in service provision locally.

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THE BRYNAWEL APPROACH

A six-month programme was developed at Brynawel which focuses upon both neuropsychological rehabilitation as well as problematic alcohol use. Admission criteria are shown in the table on the opposite page.

Clients are admitted to Brynawel following initial diagnosis and physical stabilisation (detox). Each client undertakes formal psychiatric and neuropsychological assessment at the beginning, middle and towards the end of their stay. Alongside qualitative daily observations, the results of these assessments are used to inform their individual rehabilitation plan during their stay and make any recommendations for their ongoing support needs upon discharge. Clients are supported by a dedicated ARBD team throughout their stay, with a support ratio of three to one, with the option to 'step this up to one-to-one support' if needed.

> 'Research suggests that the experiences of people with ARBD within the healthcare system are very poor.'

The assessment phase is an opportunity for clients to settle into a calm stable environment. During this time, a holistic approach is taken to supporting clients with abstinence (including thiamine), nutrition, regular sleep, and other aspects of lifestyle. Psychosocial support is introduced very early on, and engagement of family/significant

COGNITIVE AND MEMORY PROBLEMS

- Confusion regarding time and place
- Impaired attention and concentration
- Difficulty processing new information
- Inability to screen out irrelevant information
- Confabulation – filling gaps with irrelevant information
- Apathy – loss of motivation, spontaneity and initiative
- Depression and irritability

PHYSICAL PROBLEMS

- Ataxia – poor balance, disordered gait
- Damage to liver, stomach, and pancreas
- Possibility of traumatic brain injury
- Peripheral neuropathy – numbness, pins and needles in hands, feet, or legs
- Nystagmus and opthalmoplegia – involuntary eye movement

others is encouraged. Individual progress is assessment via daily observations and neuropsychological and psychiatric assessments. This data informs the care plan and is used to determine readiness to enter the treatment stage.

The aims of treatment are to develop personal autonomy and promote functional recovery. The focus is on supporting clients to improve their orientation and memory, managing their alcohol consumption and developing good relationships. The programme also focuses on working with managing impulses and behaviours, apathy and motivation.

The programme is structured around a timetable which is designed to help clients to familiarise themselves with the routines and activities of daily living. The physical environment is set up to facilitate understanding (through signs, colour coding and whiteboards) and an appropriate level of stimulation (eg noise management). Assistive technology, such as memory apps on an iPad, is used where this will be helpful.

Interventions are primarily based upon the behavioural model and include diary keeping, activity scheduling, graded tasking, problem solving and memory cueing. The 'errorless learning' approach is also used, so that clients do not make errors while learning new information.

It can take two to three years for clients to reach their full potential, and therefore resettlement and recovery in the community need to be carefully planned and psychologically informed. The individual's support needs will need to be thoroughly assessed, and a longer-term plan will need to be made to support relapse prevention and develop an appropriate level of independence and structured activities.

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BACK TO INDEPENDENCE

Brynawel's ARBD programme transformed Kate's prospects

Fifty-year-old 'Kate' was referred to Brynawel Rehab in August 2016, following a diagnosis of ARBD from her consultant psychiatrist. She had been admitted to hospital in November 2015 with a range of symptoms caused by heavy alcohol use and malnutrition resulting in seizures, ataxia and problems with articulation and swallowing reflex. Kate had trained as a nurse and worked in the NHS before and after having her family, and had been very highly regarded by her colleagues.

The results of her first neuropsychological assessment on admission to Brynawel suggested that she had difficulty planning tasks. This was evident from Kate's inability to maintain her room to a manageable standard or to plan basic self-care tasks such as showering and personal care. Initial findings from the assessment highlighted a variety of problems with her immediate memory, her visuospatial ability and her delayed memory, which was extremely low.

Her results were supportive of a diagnosis of Korsakoff's with additional complications. She underwent follow-up psychological and psychiatric assessments in November and then again for the final time in January 2017, using different versions of a battery of tests.

Kate had been very emotional on arrival, with periods of intense crying. Her sleeping and eating were quick to settle, but by week two she was noticed to have incontinence, diagnosed by a GP as anxiety-related. By the end of the first month she had begun to engage more in activities but was still noted to be unable to spontaneously initiate tasks such as keeping her room clean, although she had been able to use memory aids.

> 'Kate's results were supportive of a diagnosis of Korsakoff's with additional complications.'

Staff were able to report an improvement in her engagement and socialisation, it was apparent by the second month that she still had problems initiating communication or tasks and decision-making. Although she had managed memory tasks in sessions, her recall of these tasks later on was poor. Her symptoms of depression had lessened over the 26 weeks and her levels of anxiety were lower than when first admitted.

Kate's daughter acknowledged a marked improvement in her mother's functioning, following her admission to Brynawel. Within weeks Kate had been able to recall the daytime activities she had been engaging in and, following small prompts, she could continue an accurate conversation about what had been happening. This had been 'the first time we had noticed such a change in our mother'... 'We felt like we had our mother back!'

They were aware that Kate could not initiate memories, but she was now able to recollect things quite well with a prompt. She seemed happier and had been able to make friends with other residents. Staff from Brynawel continued to support Kate in the community for six weeks, providing support with her cognitive rehabilitation, offering assistance with memory aids and adaptations in her own home and continuing to support her reintegration into the community using a graded approach to her discharge.

A year on, Kate has maintained abstinence and lives independently. The alternative option, which was suggested before her admission onto Brynawel Rehab's ARBD Programme, was placement in a care home for the frail elderly, at 50 years of age.

Dr Alyson Smith is consultant clinical psychologist at Brynawel Rehab

dewis gwellhad Brynawel Rehab choosing recovery

Admission criteria for ARBD programme

PATIENTS WILL:

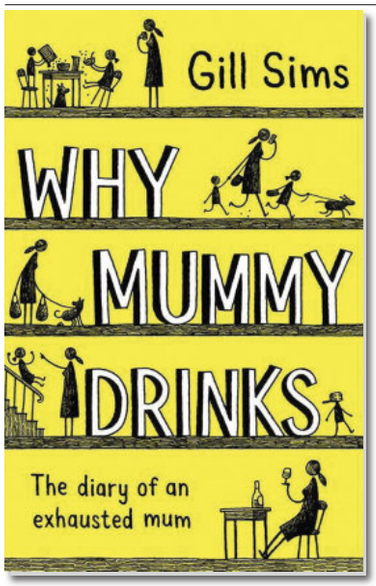
- have a diagnosis of ARBD made by a suitably qualified clinician using modified Oslin criteria. For more information see https://bit.ly/2Hm4TwV
- have a standard assessment document as part of the referral, including attached baseline scores
- have undergone physical stabilisation, ie detoxed and currently abstinent from alcohol. Be on oral thiamine supplements
- be in phase two or early phase three of Royal College of Psychiatry/ Wilson et al five-phase recovery model – for more information see https://bit.ly/2xT5vuq
- be thought to be able to engage in the components of the treatment package (eg diary keeping)

Exclusion criteria

PATIENTS WILL:

- still be in the acute confusional stage of the natural history of ARBD (and therefore still requiring medical management)
- be in late phase three, phase four or phase five (signpost to appropriate services)
- have significant physical health comorbidity where medical stabilisation is required

WHY MUMMY DRINKS - The diary of an exhausted mum



I spent much of this book wondering if the answer to the title is 'because she is an alcoholic'.

Has Ellen, 39-year-old mum of two, lost the ability to control her drinking? Mummy is at the stage when, increasingly, everything she has to do is better with alcohol – afterwards, and then, during: 'stashing a large bottle of Pimm's in my bag... made the interminable hell of sport's day pass much faster'.

Mummy says she drinks because other people are too much. Especially her young children, Peter and Jane. Like when Jane picks a paperclip off a hospital floor, and it later gets stuck between her teeth. So it's back to the hospital to have it removed. This leaves mummy 'beyond the aid of mere wine and having to resort to gin'.

Then there are other people's mummies; the 'Bloody Perfect Coven' and their obligatory middle-class extra-curricular activities: 'take children to swimming/music/tennis/dance/Jiu Jitsu'. 'So much to do, there is never enough time to do anything'. 'It's a wonder I don't drink more' listening to 'Perfect Lucy Atkinson's Perfect Mummy' say things such as 'you still eat quinoa? You should give Camargue red rice a try'. '3.45pm: 'wonder how soon I can have wine?'.

These resentments are among many unhelpful ways in which Ellen thinks. She doesn't come across as being sustainably comfortable in herself or nice to be around – except to her friends, Hannah and Sam, when they are drinking. Together they sneer at the dysfunctional relationships of other adults; split-up couples arguing about money or who sees the kids when.

Ellen thinks she is 'a terrible parent' and all aspects of parenting are an ordeal

Mummy is prone to doing other people's thinking and fuelling her self-doubt by comparing herself unfavourably to everyone else. She sits on the top deck of buses, peering into people's homes. 'What I see through all those windows are the good stories. Do people think the same when they pass my house? A nice house, a woman who has everything she could want, two beautiful children and a husband who loves her?'

In fact Ellen thinks she is 'a terrible parent' and all aspects of parenting are an ordeal. An afternoon at a soft play centre is an event for which 'there is not enough wine in the world to ease the pain'.

Her thinking jumps to conclusions, crystal-ball gazes or strives for perfection. She expects too much from everything – so a firework display, which might be exciting, is just 'being jostled in a muddy park'.

The alcohol, on almost every page, is a symptom of Mummy's sedation of all this over-thinking. What she idealises is control: '7.40 pm: enjoy a civilised gin and tonic with my loving husband as we discuss each other's days and make supportive remarks'.

This is never the reality and Ellen's conclusion is that she's 'a bored borderline alcoholic trying to pass herself off as a semi-functioning adult'.

So is the sequel going to be 'Why Mummy Goes To AA'? It's much more likely to be 'Why Mummy Swears', which she does – a lot.

Review by Mark Reid

WHY MUMMY DRINKS – The diary of an exhausted mum. By Gill Sims
ISBN: 9780008237493
HarperCollins £14.99

MEDIA SAVVY

The news, and the skews, in the national media


NEWS
WHEN DID WE STOP LISTENING TO EXPERTS?

WHEN LAW ENFORCEMENT OFFICERS CALL FOR DRUGS TO BE LEGALISED, we have to listen. So too when doctors speak up. Last month the Royal College of Physicians took the important step of coming out in favour of decriminalisation, joining the BMA, the Faculty of Public Health, and the Royal Society of Public Health in supporting drug policy reform... The BMJ is firmly behind efforts to legalise, regulate, and tax the sale of drugs for recreational and medicinal use. This is an issue on which doctors can and should make their voices heard.

***BMJ* editorial, 10 May**

LEGALISING DRUGS WOULD HALVE THE NUMBER OF PRISONERS, lead to fewer murders and overdoses, and result in safer inner cities. Only one question remains: when will a politician muster the courage and admit that legalisation would work?

Jack Powell, *Telegraph*, 11 May

WE'RE HOOKED ON A BIG LIE. How can the stupid concept of 'addiction' survive, if people such as the Relate organisation can seriously suggest that anyone is 'addicted' to sex? People pursue pleasures at the expense of others, because they enjoy them. Why do doctors, and the criminal justice system, too, help them to do this?

Peter Hitchens, *Mail on Sunday*, 6 May

NOTHING FIRES UP WE SCOTS QUITE LIKE SOMEONE THREATENING TO LENGTHEN OUR LIFE EXPECTANCY. And now, thanks to legislation that puts a floor on the price of alcohol, many of us have a reason to get upset... Yet there remains an elusive force at play in the public conversation about alcohol. Namely, the fact that so many of us who drink too much are either unaware of it or are in some form of denial. We tend to downplay or underestimate both how much we drink and the impact it has on our finances and mental health – which is why facts are useful when creating policies that are designed to tackle the issue.

Darren McGarvey, *Guardian*, 3 May

BY SOME MALIGN ALCHEMY the problem has been reconceived in recent years as harm done not by drugs but by the law. So there's been an ever-more explicit push to decriminalise all drugs, coming not just from legalisation charities but from an establishment which is increasingly in their pocket... To double down on calls for policy changes that will increase the number of drug users still farther is not to promote reform. It is a social death wish.

Melanie Phillips, *Times*, 29 May

Should we be doing more to protect people from harmful drinking, asks **Mike Ward**

DYING WITH THEIR RIGHTS ON?

Some people are so chronically damaged by alcohol, particularly through cognitive impairment, that they are no longer able to look after themselves or control their behaviour, and so pose a risk to themselves or other people. In the UK, people whose mental illness places them in a position where they can no longer live safely without harm to self or others can be detained under the Mental Health Act. This is not to punish them, but rather for protection, assessment and – hopefully – positive treatment to improve their lives.

But these powers are not easily extended to people whose problems arise mainly from heavy drinking, despite their facing many of the same challenges, and needing intensive support. Without these powers in place these people often do not receive the help they need. As a result, many end up in the criminal justice system, which does not provide them with the correct protection and treatment. This also consumes a huge amount of police time.

'It can be argued that people are free to drink, even to the point of extreme harm and death, if they choose to do so.'

In too many instances these people are never adequately supported, leading to tragic outcomes – for example in the case of Angela Wrightson from Hartlepool, who was severely incapacitated by alcohol and unable to look after herself. In the end she was killed in her own home by two teenage girls, and is now the subject of an adult safeguarding death review (https://bit.ly/2kLjObe).

How did we end up in this position? Since 1983 our mental health legislation has sought to separate problems due to alcohol misuse from those due to mental illness, with chronic alcohol problems seen as a matter of lifestyle choice. It can be argued that people are free to drink, even to the point of extreme harm and death, if they choose to do so.

But modern Britain is unusual in this. Many other economically developed countries have powers that allow for the protective and rehabilitative detention of people with chronic alcohol problems. This is true of Holland, Switzerland, France, Germany and many states in the USA and Canada. Protective detention is allowed in the European Convention on Human Rights, Article 5 (e). The language is now outdated, but the intention is clear.

These powers are not simply archaic legislation that has lingered on the statute books. A good example of this kind of legislation in action is the Swedish Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (1988).

Probably the best evidence of the positive impact of such powers comes from New South Wales, Australia. In her YouTube presentation, clinician Glenys Dore sets out the positive impact of their relatively new (2007) legislation. She describes how patients are admitted to dedicated units, with 60 per cent abstinent or improved as a result of these positive interventions.

On entry to these units all patients are screened for cognitive impairment. The average score shows that they are operating at the level of someone with Alzheimer's and some even lower. However, after four weeks in a unit their score is moving much closer to the normal range. Chronic drinking often moves beyond a matter of choice to an impaired mental state where people need outside help to break them free. At this point, they can begin once again to make choices for themselves.

The development of compulsory powers is not an easy option. It would require solid criteria and safeguarding, reinvestment in inpatient units and the development of a workforce trained to manage such clients. However, doing nothing is not a cost-free option; the current cost to the police and other emergency services, to communities and to individual lives, is immense.

People have the right to drink, even when it is doing them harm. But for some, is this a free choice? In reality, is society is doing far too little and allowing people to – in the words of Glenys Dore – 'die with their rights on'?

Mike Ward is senior consultant for the charity formed by the merger of Alcohol Concern and Alcohol Research UK, www.alcoholresearchuk.org

In his next article, he will discuss the problems with the legislation currently used to meet the needs of heavy drinkers who cannot look after themselves: a patchwork of the Mental Health Act, Mental Capacity Act and the Care Act.

Sweden's *Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act* (1988)

The Act's aims are to *'immediately stop a destructive way of life; motivate patients to seek further treatment, if such a process is required; and to overcome addiction and hence achieve a better lifestyle.'* Under the Act, social workers must take a person into treatment if they match the four criteria set by the Swedish government:

- *If the individual is risking his/her psychological health on purpose or by helplessness*
- *If the individual is destroying the prospect of his/her future due to substance misuse*
- *If the individual is risking the security of him/herself or intimate associates*
- *Necessary intervention is not possible on a voluntary basis.*

More on prison policy at:
www.drinkanddrugsnews.com

The launch of the 'Decency, safety, security' strategy for prisons was greeted with mixed reactions by the Drugs, Alcohol, and Justice Cross-Party Parliamentary Group. **DDN** reports

BANG FOR YOUR BUCK

The new prisons strategy promised a 'back to basics' crackdown on drugs and mobile phones, while also intending to 'keep prisoners busy' by tasking them with cleaning up yards and picking up rubbish, explained prison minister Rory Stewart. It would be piloted across ten prisons, and rolled out across the rest of the prison estate if successful.

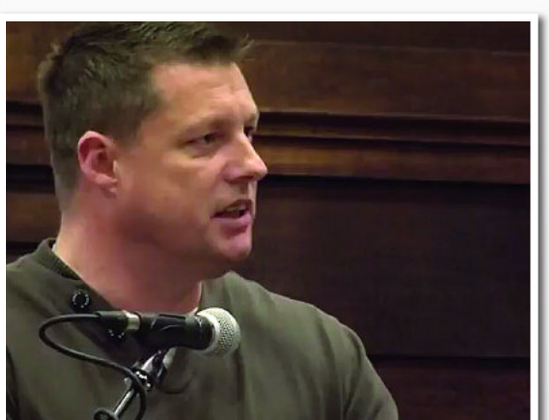
Joe Simpson, assistant general secretary of the Prison Officers Association, praised the strategy's intentions but questioned if there would be the resources to back it up. He mentioned the importance of stopping drugs 'at the wall and the gate' but said there were not enough officers to do this. 'There is lots of legislation, but not enough people to enforce it', he said.

Prison officers had been calling for mobile phone blocking since 2007, he said, and while the technology was available it wasn't being used, which he claimed was down to cost. Tools available to prison officers to tackle drug use such as mandatory drug testing (MDT) and random cell searches had unintended consequences, and could lead to changes in drug using behaviour and increased bullying, as inmates were intimidated into holding drugs for dealers.

'All we are doing is warehousing prisoners, then breathing a sigh of relief if we get them out alive,' said Simpson. 'As a prison officer you see the misery caused by drug use', he added, and emphasised the need for an integrated approach that looked at the reasons people use drugs and associated psychosocial issues. But doing this 'needs proper resourcing'.

This theme was echoed by Majella Pearce, deputy head of healthcare for HM Inspectorate of Prisons. She highlighted that 'substance misuse doesn't happen in isolation'; that very good substance misuse services in prison were not enough, and that there was an urgent need for wraparound services.

Of 39 prisons that had been inspected, only a third met the required standard, 28 per cent of prisoners had reported a problem with drugs and 14 per cent with alcohol. Changing drug use within prisons was a big issue, with diverted medication and NPS being the key concerns. The use of drug testing was driving this as prisoners moved away from cannabis to drugs that leave the system quicker and are harder to detect.



'There is lots of legislation, but not enough people to enforce it.'

JOE SIMPSON

Dedicated drug recovery wings were not the only answer and varied in their effectiveness – but when done well could be very effective, she said. This was especially the case when there was integrated mental health care and drug treatment: prisoners were more likely to engage as they perceived less stigma around mental health issues.

Louise Scherdel, project manager at Addaction, told the group about Addaction's approach to working in jails in Lincolnshire. On reception, every prisoner was offered a chemical assessment, then seen again the next morning and offered specific harm reduction advice relating to the drugs most commonly reported in the prison. Scherdel said that NPS users were less likely to engage than traditional drug users, but initiatives using music and art therapy had been shown to be effective. While lack of resources meant that they were currently unable to implement a full recovery wing – but ran a programme on a landing – anecdotal evidence pointed to an 89 per cent completion rate.

The charity worked with prisoners on release with its 'through the gateway' programme, linking prisoners with treatment services in the area and family support teams, and providing harm reduction services such as take-home naloxone on release.

'There is a focus on enforcement and reducing supply,' commented Alex Boyt, as discussion opened up to the group. 'But a lot of drug use is linked to depression – if you are banged up 23 hours a day and under threat of violence from other prisoners, you are more likely to self-medicate. It creates a vicious downward spiral.'

More personal stories at www.drinkanddrugsnews.com

Last year Kelly's Story won the Recovery Street Film Festival. In 2015, Kelly Judge was sleeping rough on the streets of London with no support network. Her children had been taken into care and she was unsure how long she would survive. Interview by **Chris Franks** from CGL

A WINNER'S TALE

What were you feeling at this point in your life?

'I was at the end of a very long, treacherous road. I was beaten down and I was alone. I had no family around me, I had no friends around me. I was completely isolated, a shell of a person. I couldn't see a way out of it. I knew there was something that needed to be done but I didn't know how to get the help and I didn't know if I could actually do it after 16 years of using drugs. Everything in my life was a question mark.'

Tell us about your experience of making the winning film for the 2017 festival, Kelly's Story (produced by Jeremiah Quinn).

'My biggest motivator was to let people know that if I can do it, then so can they. Part of the process of being in recovery is giving back to others in recovery. I was really nervous when I was told I was going to meet this guy at Trafalgar Square so he could film where I used to be, and then come back to the service for the main part of the interview. I was nervous about what he was going to ask me and what was expected of me. I met Jeremiah, who was making the film, and he put me at ease completely. I just told my story to him and didn't think about anyone seeing it. I never thought so many people would see it and come up to me and say, "I saw your film, it was amazing."

'The biggest thing I learnt from the experience was that I have the ability to get a message across, just by being myself. I'm just telling my story. I've lived it, and that's all I'm talking about. When someone gets impacted by that it makes me feel like I've accomplished something – knowing that it can reach someone, knowing that someone can hear my story and it be similar to theirs and they can recognise that change is possible.'

How did you feel when you found out the film had won?

'When I got told I had won, I was going through a difficult time. It was like a silver lining. I thought, how wonderful, someone's thought that much of the film to give it first place. It made what was happening a little easier.'

> 'As a judge for the festival this year I will be looking for authenticity, simple as that...'

What will you be looking for, as a judge of this year's film festival?

'As a judge for the festival this year I will be looking for authenticity, simple as that. I don't need to see loads of bells and whistles and clever effects. I just want to see someone telling their story, making it real. When something is simple you get less distracted and can pay attention to the story you're being told.'

What advice would you give to someone who is thinking about making a film for the festival?

'You've got the chance of not only changing your life, but someone else's too. Even if it's one in a million, it's worth it. Seeing your video might be that lightbulb moment they need.'

You can watch Kelly's Story on the Recovery Street Film Festival YouTube channel, and the submission window for the 2018 Recovery Street Film Festival is now open. Visit rsff.co.uk for more information and to submit your film.

cgl™
change,
grow,
live

Could you help people achieve their potential?

Change Grow Live (CGL) offers a wide range of employee and volunteer opportunities which can encourage behaviour change, improve health and relationships and make a real difference to people's lives. We currently support 57,000 people each day.

We value creativity and initiative and you will be encouraged to contribute your ideas to the development of our substance misuse, health and social care and criminal justice services. We work with adults, young people and families and roles include nurses, recovery workers, service managers and team leaders.

We offer employees:

- A professional and supportive environment
- An hour a week to spend doing something positive for your personal wellbeing
- A competitive salary
- 25 days annual leave (rising to 30 days per annum)
- A generous contributory pension scheme
- Personal and professional development, including training courses, mentoring programmes and time off to pursue relevant qualifications.

Volunteers can also gain valuable experience and many of our volunteers go on to gain paid roles.

We are an equal opportunities employer and hold the prestigious Investors in People Silver award.

For further information about the roles we have available please visit www.changegrowlive.org/jobs

CHANGE GROW LIVE

Our mission is to help people change the direction of their lives, grow as a person and live life to its full potential.

Change Grow Live (CGL) Registered Office: 3rd Floor, Tower Point, 44 North Road, Brighton BN1 1YR. Registered Charity Number in England and Wales (1079327) and in Scotland (SCO39861). Company Registration Number 3861209 (England and Wales).

STEPS TOGETHER. REHAB
STRONGER TOGETHER

Steps Together Rehab is a specialist drug and alcohol rehabilitation provider.
Our philosophy is to help individuals become sober and drug free and to help build a life of hope and freedom for their future. We are opening a new centre in Leicester and have the following exciting opportunities:

REGISTERED MANAGER *(start date: June/July)*
You will be responsible for the running of the centre, and maintaining high standards to meet and exceed CQC regulations. We require a level 4 or 5 in Health & Social Care or to be working towards one. A qualified RMN or RGN nurse is preferable, and you must have at least two years managerial experience in substance misuse or running other care homes.

OPERATIONS MANAGER *(Start date: June/July)*
Responsible for overseeing the smooth running of Steps Together Rehab Nottinghamshire and Leicestershire. A Health & Social Care qualification or another diploma would be required, and experience management in the addiction field and knowledge of CQC requirements.

NURSES *(Start date: August/September)*
We are looking for qualified RGN or RMN nurses to support our clients and be part of our fantastic team. You must have current pins up to date, be able to administer medication and take physical observations. Experience working in substance misuse is essential.

ADMISSIONS CO-ORDINATOR *(Start date: July)*
A very exciting opportunity to work with our growing brand, taking calls from initial enquiries, and assessing clients pre-treatment. You will support the nursing and management teams and must have at least two years in the addictions field.

SUPPORT WORKERS *(Start date: TBC)*
You will assist our clients outside the group room. Working closely with our nurses, you will be able to communicate well and support our client group. Must have an NVQ L2 or L3 in Health and Social Care and be able to administer medication.

All salaries are negotiable and we offer a generous holiday and benefits package.
Please email CV's and enquiries to: darren@stepstogether.rehab

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care UK Healthcare

I treat more than just symptoms.
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Have you ever thought about working in prison healthcare?

Prisons are one of the most challenging, yet rewarding places for healthcare professionals to work - if you're looking to develop your existing skills and learn something new every day, then this is the place to be.

We are the leading provider of prison healthcare services in England and we believe in putting the patient first, regardless of the environment or their history.

We have opportunities for substance misuse nurses (RGN or RMN) to work in our multi-disciplinary teams on a full-time, part-time and bank basis.

Whether you're new to prison healthcare or not, all our employees benefit from support and mentoring throughout their first six months and beyond.

Call us today to find out more on
01189 521874 or email us at
healthcare.recruitment@careuk.com

Forward

Substance Misuse Nurse Opportunities – Band 5, 6 & 7

At Forward Trust we are passionate about supporting those with Drugs and Alcohol issues within community services or prisons. We strive to enable our nurses to have the time and the space to be the best that they can be for our client base. We are always eager to hear from registered nurses with a passion for working with addiction clients.

Alongside Simply Health Coverage, competitive annual leave entitlements and a contributory pension scheme to assist employees with their general health and well-being we offer:

- ☑ *Competitive Salary against agenda for change*
- ☑ *Flexibility in work pattern*
- ☑ *NMC Pin Paid*
- ☑ *Revalidation Appraisal online portfolio including a journal subscription*
- ☑ *Attendance of one UK conference per year per nurse*
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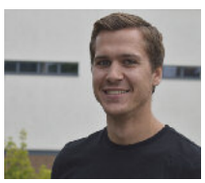

"There are very few other opportunities in which you can see your work being implemented in a way that has such a significant impact on the lives of others."

Ayden, Forward Business Development Executive

For further information please feel free to email:
recruitment@forwardtrust.org.uk or visit www.forwardtrust.org.uk/work-for-us/

We are committed to equality of opportunity. We select candidates based their abilities and skills and nothing else. We are dedicated to enhancing the diverse profile of our organisation to reflect the communities within which we work.

Improving the management of severe mental illness and substance misuse

DUAL DIAGNOSIS

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