DRINK AND DRUGS NEWS ISSN 1755-6236 JULY/AUGUST 2018

DDN

INSIDE:

PROACTIVE HEALTHCARE FOR LONDON'S STREET HOMELESS

PERFECT PARTNERS?

TIME FOR CHARITIES TO MEET THE PRIVATE SECTOR

PLUS: Patchy naloxone provision is risking ex-prisoners' lives

NHS
Substance Misuse
Provider Alliance

CONFERENCE 2018: BEHAVIOUR CHANGE

9.30 - 4pm
17th September 2018

The NHS Substance Misuse Providers Alliance invite you to join us for our 2018 conference.

The conference will bring together a range of speakers who will be sharing their innovations and expertise, offering insight into how we can provide individuals with the best chance of achieving positive behaviour change.

This will include showcasing the best that the NHS has to offer in the fields of drug and alcohol addiction, as well as venturing into new and developing debates such as how we can intervene positively for those suffering with gambling addiction.

To book your ticket, please visit: https://nhssmpa_2018.eventbrite.co.uk

Conference venue:
Wellcome Collection
183 Euston Road
London, NW1 2BE

About the NHS SMPA:
www.nhssmpa.org

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EDITOR'S LETTER

'Partnerships have brought a culture change'

Tackling stigma is always a challenge, so we were interested to hear of Double Impact's strategy to connect with business and employers (this month's cover story). Looking at ways to raise funding, they worked hard to create productive partnerships with local businesses, which have not only opened up income streams but helped to bring about culture change. Their progress in creating meaningful employment opportunities and experience is heartening.

Changing culture is proving as difficult as ever at policy level. Why is naloxone not being provided to prisoners on release, when drug-related deaths are the main cause of mortality during the first week of release (page 14)? How can we be going round in circles on tackling drug-related deaths when this straightforward intervention could save so many lives? As John Jolly says, 'please NHS, help sort this out'. We have the knowledge and the kit to act on this now.

One area where we need to build up knowledge quickly is around gambling addiction, and NHSSMPA's article on page 12 shares the example of a clinic that provides much-needed help. And while we're looking at different approaches to treatment, does acupuncture deserve a place in the treatment armoury? Natalie Davies examines its effectiveness on page 8. We've been delighted with the response to our first Wider Health supplement on alcohol in last month's issue, and our feature from visiting a clinic at a homeless practice on page 10 demonstrates frontline holistic healthcare at its most effective.

Have a great summer and see you in September!

Claire Brown, editor

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

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SCOTLAND RECORDS HIGHEST EVER DRUG DEATHS

SCOTLAND HAS YET AGAIN RECORDED its highest ever number of drug-related deaths, at 934. The 2017 figure is 8 per cent up on the previous year (*DDN*, September 2017, page 4) and more than double the number from a decade ago. Scotland's drug-death rate remains the highest of any EU country, and is around two and a half times that of the UK as a whole.

Almost 40 per cent of the deaths were of people aged 35-44 and just under 30 per cent were in the 45-54 age group. Males accounted for 70 per cent of the deaths. As in previous years, the Greater Glasgow and Clyde NHS board area recorded the highest proportion, at 30 per cent. Opioids were implicated in 'or potentially contributed to' 87 per cent of the total number of deaths, with benzodiazepines implicated in or potentially contributing to 59 per cent.

The 'sheer toll' of drug-related deaths represented a 'staggering weight carried by families and communities and the wider Scottish nation', said Scottish Drugs Forum CEO David Liddell. 'Just over 10,000 people have now died since these figures were first issued in 1996. That is the equivalent of the entire population of a Scottish town like Fort William or Stranraer or Methill or Haddington. Last year was a record high – and so was the year before and the year before that.'

Although Scots were now more than five times more likely to die from drugs than in traffic accidents the deaths were 'entirely preventable', he stated. 'We know how to prevent drug-related deaths – and yet we don't do all that we could to prevent them.' It was vital that people had access to 'high quality healthcare and support', he stressed, as well as being removed from 'the dangers of unregulated street drugs'.

'A new Scottish drugs strategy is due to be announced – imagine it was based on the notion that people had the right to life,' he said.

Although the vast majority of deaths were among men, the percentage increases between 2003-07 and 2013-17 were far higher for women – at more than 200 per cent – and a separate report suggests that reasons may include increasing rates of physical and mental health problems among women who use drugs, as well as factors such as abusive or coercive relationships, sex work and the impact of welfare reform.

Meanwhile, a new report from Blenheim says that uneven provision of naloxone is contributing to high rates of fatal overdose among prisoners in the period immediately after release, a situation CEO John Jolly described as 'totally inexcusable'. 'Too many people are falling through the gaps and too many people are dying,' he said.

Drug-related deaths in Scotland in 2017 at www.nrscotland.gov.uk

Why are drug-related deaths among women increasing in Scotland? at www.gov.scot

Failure by design and disinvestment: the critical state of custody-community transitions at blenheimcdp.org.uk

John Jolly writes about prison naloxone provision on page 14

'We know how to prevent drug-related deaths – and yet we don't do all that we could to prevent them.'

DAVID LIDDELL

PEAK PRODUCTION

RECORD-HIGH PRODUCTION levels for opiates and cocaine, coupled with expanding drug markets, mean the drugs are now a 'bigger global threat to public health and law enforcement than ever before', according to UNODC's latest *World drug report*. Global opium production grew by 65 per cent between 2016 and 2017, the highest estimate ever recorded by UNODC, with production in Afghanistan increasing by 87 per cent (*DDN*, December/January, page 4). Global cocaine manufacture, meanwhile, also reached its highest ever level in 2016, at an estimated 1,410 tons.

World drug report 2018 at www.unodc.org

MINIMUM MATTERS

THE NATIONAL ASSEMBLY FOR WALES has approved the introduction of minimum unit pricing (MUP) for alcohol. Approval of the 'landmark' Public Health (Minimum Price for Alcohol) (Wales) Bill, which was introduced last year (*DDN*, November 2017, page 4) means that MUP will become law as soon as it has received Royal Assent. Wales sees around 55,000 alcohol-related hospital admissions a year, at a cost to the NHS of more than £150m.

SHORT SHRIFT

Three in five people sent to prison for sentences of less than six months report a drug or alcohol problem on arrival, according to FOI data obtained by the Revolving Doors Agency. The data demonstrates the need for a 'radical new approach', says the organisation, which has also published a report on the 'critical' role of police and crime commissioners in addressing substance misuse. 'This is robust evidence of the need to tackle problems earlier to prevent the cycle of crisis and crime,' said chief executive Christina Marriott. *Spotlight on substance misuse: emerging good practice across PCC areas at www.revolving-doors.org.uk*

BIG UNITS

ENOUGH ALCOHOL WAS SOLD in Scotland in 2017 for every adult to exceed the weekly guideline by 40 per cent 'every week of the year', according to NHS Scotland. More than ten litres of pure alcohol per adult were sold, says *Monitoring and evaluating Scotland's alcohol strategy*, equivalent to 19.6 units per person per week. 'With rates of alcohol-specific deaths increasing in recent years, and alcohol-related hospital admissions four times higher than they were in the 1980s, it is more important than ever that we continue to monitor alcohol price, consumption and alcohol-related harms to inform and evaluate policy,' said lead author Lucie Giles. *Report at www.healthscotland.scot*

CANADIAN CANNABIS

THE CANADIAN SENATE has voted through the Cannabis Act (*DDN*, June, page 4), meaning that adults will now be able to legally purchase, grow and use a limited quantity of the drug. 'I am proud of the work accomplished by our government, parliamentarians, and all Canadians who contributed to this important shift in our country's approach to cannabis,' said justice minister and attorney general, Jody Wilson-Raybould. 'Our goals are to protect our youth from the health and safety risks of using cannabis and keep criminals and organised crime from profiting from its production, distribution and sale.' UNODC, however, issued a statement saying that it 'regretted' the decision, which would undermine the 'international legal drug control framework and respect for the rules-based international order'.

'Our goals are to protect our youth...'

JODY WILSON-RAYBOULD

HOME SECRETARY LAUNCHES MEDICINAL CANNABIS REVIEW

THE GOVERNMENT IS UNDERTAKING A REVIEW of the medicinal use of cannabis, home secretary Sajid Javid has announced. The move follows headline stories about the parents of two children with epilepsy – Alfie Dingley and Billy Caldwell – being unable to legally access cannabis oil-based medicines that can prevent seizures. In both cases emergency licences have since been issued.

'I have now come to the conclusion that it is time to review the scheduling of cannabis,' Javid told the House of Commons. However, it was 'absolutely clear' that the move was 'in no way a first step to the legalisation of cannabis for recreational use,' he stated. 'This government has absolutely no plans to legalise cannabis, and the penalties for unauthorised supply and possession will remain unchanged.'

The first part of the review, overseen by chief medical officer Professor Sally Davies, has already concluded that 'there is evidence of therapeutic benefit for some conditions'. The second part, to be carried out by the Advisory Council on the Misuse of Drugs (ACMD), will now assess whether cannabis-related medicinal products should be rescheduled, with a decision likely to be reached by the end of July.

'There is clear evidence from highly respected and trusted research institutions that some cannabis-based medicinal products have therapeutic benefits for some medical conditions,' said Davies. 'As schedule 1 drugs by definition have little or no therapeutic potential, it is therefore now clear that from a scientific point of view keeping cannabis-based medicinal products in schedule 1 is very difficult to defend. Let me be emphatic – this report does not look at recreational cannabis use and does not endorse or condone recreational use. There is well-established evidence on the potential harm of recreational cannabis use.'

An expert panel – led by chief medical officer for Northern Ireland, Dr Michael McBride – has also begun accepting applications from clinicians to prescribe cannabis-based medicines. Applications would be 'considered and endorsed on the basis of best clinical practice in order to ensure safe and appropriate care for patients', said McBride.

The announcement of a review followed an article in the *Telegraph* by former Conservative leader William Hague that called for a complete overhaul of the 'failed' policy on cannabis – including for recreational use – and stating that 'official intransigence is now at odds with common sense'. The drugs policy lead for the Police Federation of England and Wales has since also stated that drug legislation is 'outdated' and 'ineffective'. 'The proliferation of drugs in this country is unchecked and the current situation is fuelling an illicit trade in not only drugs but weapons and the violence that comes with it,' said Simon Kempton. 'Although the police service will continue to uphold the laws passed by Parliament – a public debate is needed on the future of drugs legislation, incorporating health, education and enforcement programmes.'

'A public debate is needed on the future of drugs legislation...' SIMON KEMPTON

Meanwhile, the Institute of Economic Affairs has become the latest think tank to publish a report on the potential financial benefits of legalising cannabis, with its *Joint venture* document valuing the UK's cannabis black market at £2.6bn. Legalisation could raise £1bn a year in tax revenues, it states, 'before considering savings to public services'. The report follows similar documents from Health Poverty Action and the Taxpayers' Alliance (*DDN*, June, page 40.

Joint venture: estimating the size and potential of the UK cannabis market at iea.org.uk

STANDING IN

ADFAM POLICY AND COMMUNICATIONS DIRECTOR Oliver Standing has been appointed the new director of Collective Voice, and will replace Paul Hayes in mid August. 'I am delighted to welcome Oliver to Collective Voice,' said chair Karen Biggs. 'He impressed the panel with his passion for the work the sector does. The board is looking forward to working with Oliver, building on the significant achievements made over the last three years under the expert leadership of Paul Hayes.'

Oliver Standing is new director of Collective Voice

SCANDALOUS STATISTICS

NINE OUT OF TEN OF PEOPLE who died while sleeping rough last year 'needed support for mental health, drug or alcohol problems', according to research by St Mungo's. The number of people sleeping rough in England has risen by almost 170 per cent since the start of the decade, and the charity has written to the prime minister calling for urgent action to prevent more people dying on the streets and to ensure that all parts of the public sector 'play their part'.

'This is nothing short of a national scandal,' said chief executive Howard Sinclair. 'These deaths are premature and entirely preventable.' *Dying on the streets: the case for moving quickly to end rough sleeping at www.mungos.org*

BANGLADESH BRUTALITY

NEARLY 200 NGOS HAVE WRITTEN TO UNODC and INCB calling for urgent action to prevent further deaths and human rights violations 'in the name of drug control' in Bangladesh. More than 130 people have been killed and 13,000 arrested since prime minister Sheikh Hasina launched a national anti-drugs campaign in May. As is the case in the Philippines, deaths are frequently justified as the police acting in 'self-defence', say activists. 'As human rights abuses in the name of a war on drugs are increasing every day around Asia and are now seemingly the "new normal", it may have given false hope for certain political leaders that they no longer have to account for killing their own poor and vulnerable citizens,' said coordinator of the Asian Network of People who Use Drugs, Anand Chabungbam.
Open letter at idpc.net

BUOYANT BUYERS

COCAINE PURITY LEVELS IN EUROPE are at their highest for a decade, according to the latest EMCDDA annual report, with a 'buoyant' market and increased availability of the drug in a number of countries. Wastewater analysis revealed increased cocaine residues in 26 out of 31 European cities, with those showing the highest traces in Spain, the UK, Belgium and the Netherlands.

NPS also remain a 'considerable policy and public health challenge', says the agency, with more than 50 reported to the EU's early warning system for the first time in 2017, bringing the total that the EMCDDA is now monitoring to more than 670.
European drug report 2018: trends and developments at www.emcdda.europa.eu

Perfect partners

As competition for funding heats up it's time for charities to form meaningful and creative partnerships with the private sector, says **Eleanor Youdell**

In May this year East Midlands-based drug and alcohol recovery charity Double Impact marked its 20th birthday with our Spirit of Recovery Awards – an awards ceremony that celebrates the transformative power of recovery and recognises service users, staff, volunteers, and partner organisations for their various achievements and support over the past 12 months.

The event received support and sponsorship from a wide range of private sector companies, including Nottingham's Park Plaza hotel, which hosted and catered the 150-person event at no cost.

One of Double Impact's wider goals as a charity – beyond the direct support it provides to those in recovery – is to help break down the societal stigma of addiction. Reaching out and making connections to businesses and employers is an important way of achieving this, as well as raising awareness outside of the third sector.

With public sector funding shrinking and competition for grants increasing, charities are being forced to focus on a wider range of potential funding sources, and we are no exception. Support from the private sector is more important than ever, but how do smaller organisations compete against the plethora of local and national charities with more popular and media-friendly causes than addiction – something that can still be perceived by many to be a lifestyle choice rather than a health issue.

Double Impact has responded to this challenge in a number of ways. Firstly we have embedded employer engagement into a number of our grant-funded projects, such as Recovery Recruitment, a Big Lottery funded initiative that has operated in Nottinghamshire for a number of years. The primary vehicle for this is free drug and alcohol awareness training for local employers, angled towards meeting their needs and addressing issues within their own workforce, and building in participation from volunteers in recovery. The volunteers are able to directly challenge preconceived ideas about 'addicts' or 'alcoholics' and deliver a powerful message that people in recovery can make as good – if not better – employees as anyone else.

Fruitful relationships have developed with Primark, HMRC, Cineworld, Games Workshop and most recently local confectioners The Treat Kitchen, and several employers have given their support through hosting mock interview sessions that help to prepare people in recovery to re-enter the workplace.

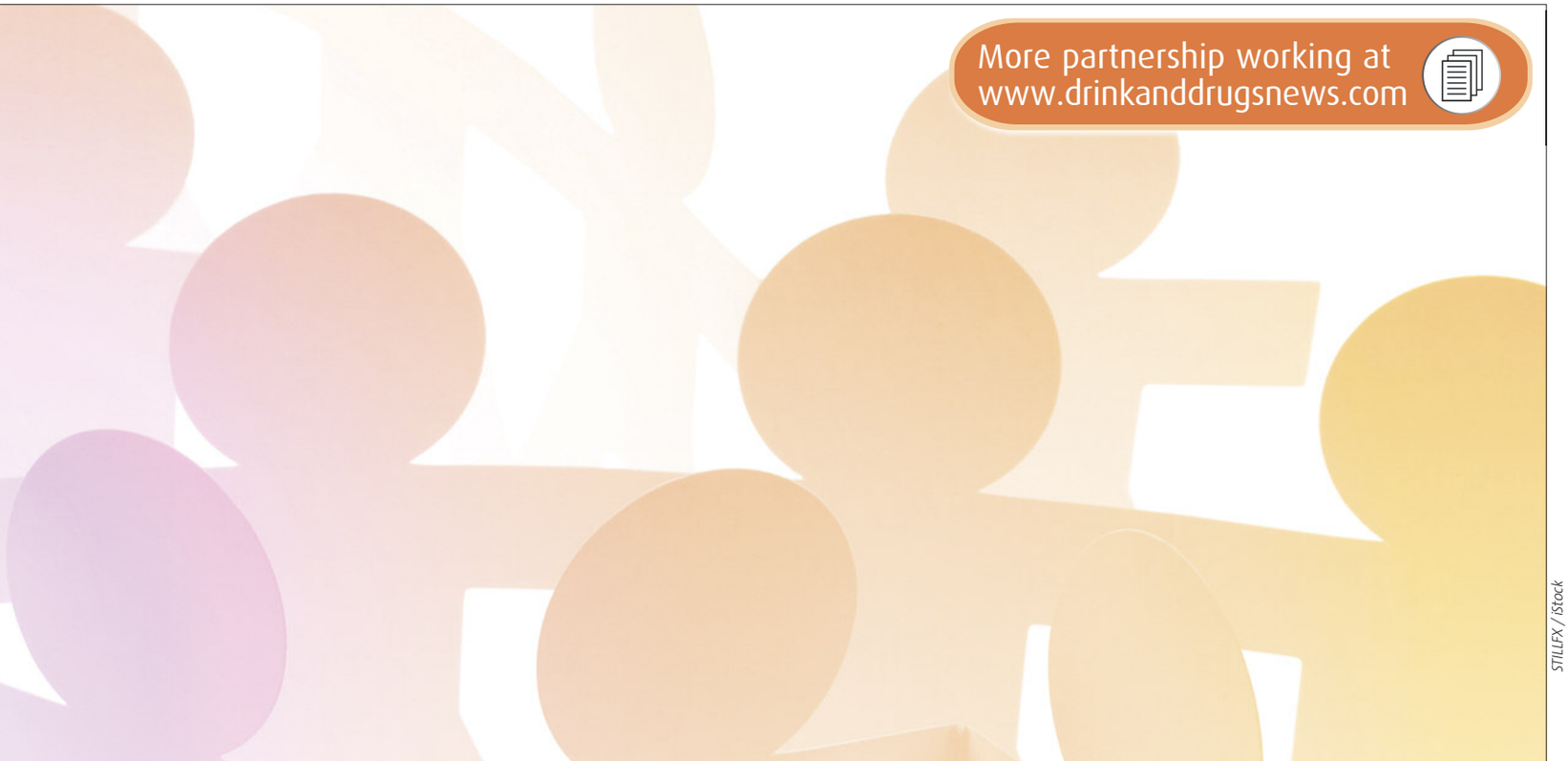
The charity has also raised its profile through our Café Sobar social enterprise, a high street café and alcohol-free venue that is always bustling with city centre shoppers and workers. Set up in 2014, again with the support of a Big Lottery Fund grant, this provides a safe social venue and space for business meetings, community and recovery-focused groups, as well as volunteering opportunities for people in recovery. While the challenge of creating and sustaining a successful business is not to be underestimated – especially for a smaller charity such as Double Impact – we believe it has reaped many benefits in terms of the charity's ability to engage with the private sector.

> **'How do smaller organisations compete against the plethora of local and national charities with more popular and media-friendly causes than addiction?'**

Café Sobar literally acts as a shop window for the work of the charity. There is always a mix of people in the café and it's never obvious who is in recovery and who isn't, which in itself helps to challenge stereotypical ideas of what addiction looks like. The café provides a way for us to attract business people in a very low-key way, for example through hosting business breakfasts, offering affordable meeting room space or just providing a pleasant place for people to come to have a meeting over coffee or do some work. This means business people are exposed to our cause in a non-threatening and positive way, and can feel good about supporting us through the cost of their usual cup of coffee. Often this then leads on to us being offered other kinds of support.

There are several good examples of this – contact with The Treat Kitchen was initially made through the café, with both businesses planning and participating in a Halloween event together. After becoming aware of the positive impact we were

More partnership working at www.drinkanddrugsnews.com



STILLFX / iStock

having locally, the company expressed an interest in taking on some Recovery Recruitment participants as volunteers, and then took even greater strides in their support by naming Double Impact their charity of the year.

'With the volume of collaboration we do with Café Sobar it seemed only natural to pick Double Impact as our chosen charity,' says The Treat Kitchen's owner Jess Barnett. 'We admire what they do and would like to support it and the service users as much as we can. Offering placements within different parts of our business is a great way to do this.'

The relationship is now thriving with several volunteers having successfully gained work experience in various parts of their business. The employers also generously ran an open competition to design a Double Impact sweet, and the winning flavour (chilli and chocolate) is soon to hit the shelves, with all profits going back to the charity. Four of their staff are also raising money by running in the Robin Hood half marathon.

Similarly, a local business club that held an event in the café then invited our CEO to speak at its Christmas lunch – as well as the cash donations generated as a result, the real opportunity was in being able to reach out to so many business people at once, and so far it has resulted in several people committing to run in the Robin Hood marathon for us and sponsor our Spirit of Recovery Awards.

'The primary vehicle [for us] is free drug and alcohol awareness training for local employers angled towards meeting their needs...'

Our current 20th anniversary fundraising appeal has also provided a focal point for businesses to do something for the charity. Over the course of the anniversary year, CEO Graham Miller has been raising funds and awareness through undertaking to run 20 half-marathons in one year.

Combining a popular fundraising activity like running with a story that has caught the imagination of the local media has enabled us to attract support from many people in the private sector, who may have come into contact through the café or heard Graham speaking at a business lunch event. The appeal has also meant we've needed to brush up our social media skills, and having a longer-term appeal that generates regular news and updates has enabled us to connect into businesses' social media networks in a meaningful way.

'All this is common sense stuff really, but it still feels quite new for us, as it's easy to shy away from this sort of fundraising due to the sense that it's an "unsexy"' cause – perhaps being guilty ourselves of succumbing to a kind of stigma,' says Graham. 'In fact, what this year has shown us is that there are many supporters out there, including forward thinking individuals within the business sector, who aren't afraid to do something different and show their support. Often you find out that there is a personal connection to the cause – as we know, conservative estimates say that one in ten people experience addiction and that this in turn directly affects another seven – so there are plenty of people out there who are affected by this.'

How does all this reduce stigma? The increased willingness of employers to give people in recovery a chance has a huge impact on the individual, and can help to restore confidence and self-belief. Among those employers, HMRC has played a big part in helping service users to take that big leap into the job market by holding mock interview sessions.

'My colleagues and I were impressed not only by the fortitude and resilience shown by the interviewees, in the face of what have clearly been very difficult circumstances for them, but also particularly by the enthusiasm and positive attitudes which they all demonstrated during the interviews,' says Julian Bentley, who was involved in the process. 'We hope that HMRC have been able to contribute, if only in a small way, to helping the interviewees obtain employment.'

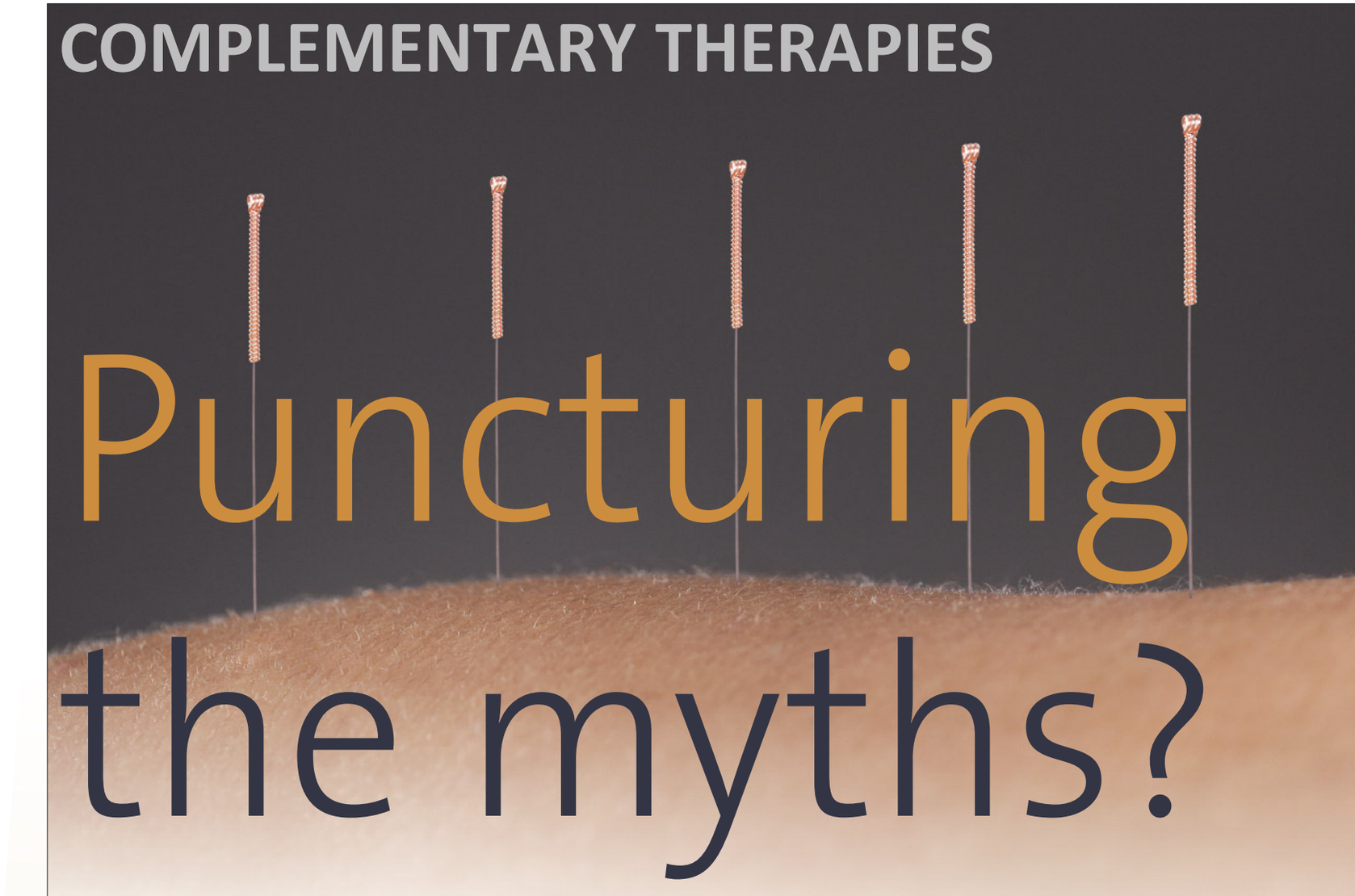
'I was fearful about interviews because the atmosphere is uncomfortable and the spotlight is on me,' says Tom, one of the interviewees, who is now working full time as an administrator. 'The mock interviews held at Double Impact with staff from HMRC were a great opportunity to practise being in that atmosphere, have a go at answering questions that I don't usually get asked, and most importantly get feedback on how well I performed.

'Interviews have been few and far between for me so I gained a lot from the mock interviews, and I felt more confident going into a real interview a few months later. The experience and tools helped me to secure employment earlier this year.'

'It's hard to measure something as intangible as a reduction in stigma, but we believe we're contributing to a larger movement and the response we're having locally is very encouraging,' says Graham. 'It's great to have support from businesses that aren't afraid to lead the way, do something different and make a statement about it – like most things in life, where one goes, another will follow. The willingness of the private sector to demonstrate support for recovery from addiction is worth so much more that any actual financial contribution.

'It might not be normal yet for a big corporate to choose an addition charity as their charity of the year, but the response I've had from the general public and from the private sector to my running tells me that the tide is beginning to turn.'

Eleanor Youdell is business development manager at Double Impact



Puncturing the myths?

A recent essay published by *Drug and Alcohol Findings* asked whether acupuncture can treat acute substance use problems and disorders or relieve symptoms of withdrawal, and included a healthy dose of scepticism about whether acupuncture 'works' at all. No doubt some readers thought it went too far in its criticism of acupuncture, and others that it had not gone far enough to distance the practice from accepted evidence-based treatments.

Building on that essay, I want to explore how language may be blurring the lines between alternative and conventional treatments, and why resistance to acupuncture may be more an issue of ethical resistance to placebos, making acupuncture a topical vehicle through which to debate their use.

Traditional acupuncture has been developed over 2,000 years in China, Japan, and other East Asian countries. A self-regulated profession in the UK, traditional acupuncture is delivered outside the NHS alongside other alternative and complementary therapies. Western medical acupuncture, on the other hand, is sometimes available on the NHS but most often paid for privately, and delivered by medical practitioners such as doctors, physiotherapists and nurses as an add-on to their conventional professional practice.

The NHS Choices website doesn't equate acupuncture with conventional treatment, but does distinguish 'Western medical acupuncture' from 'non-medical acupuncture' or 'traditional Chinese medicine acupuncture' – the first at least *sounding* more like a conventional treatment. Allied with this is the medical language explaining how it works and the stipulation that Western medical acupuncture is used following a medical diagnosis.

Traditional acupuncture is based on the idea that problems with our health and wellbeing can surface when vital energy known as Qi (pronounced 'chee') is prevented from flowing freely throughout the body, and works by restoring the flow of this so-called 'life force'. In contrast, Western medical acupuncture reincarnates acupuncture as a procedure that stimulates sensory nerves (as opposed to 'energy') under the skin and in muscles, causing the body to produce endorphins and other naturally-occurring chemicals.

Acupuncture adherents cite the benefits of treating the person not the condition, and claim in doing so that acupuncture can not only maintain good health and prevent bad health, but improve one's overall sense of wellbeing. For people so inclined, the gentle insertion of hair-thin, flexible needles is reported to be relaxing, and at the site of the needles is sometimes associated with pain-free feelings of heaviness, aching, tingling and warmth.

For the NHS, acupuncture is currently only recommended for chronic tension-type headaches and migraines, but is also used to treat other types of pain. In the substance use field acupuncture has been a popular alternative treatment for people with cocaine use problems – though this may have had more to do with the lack of an accepted conventional treatment than the particular merits of acupuncture, and the need for acupuncture itself may be illusory as just about any psychosocial therapy helps *some* of these clients *some* of the time.

A 2006 assessment from the respected Cochrane collaboration of whether acupuncture at sites on the ear has helped in the treatment of cocaine dependence found definitively that, 'There is currently no evidence that auricular acupuncture is effective for the treatment of cocaine dependence'. As evidence was limited and from methodologically poor studies, the assessment stopped short of saying that acupuncture was ineffective[1]. Across the spectrum and range of substance use issues, the same or similar conclusions apply.

It could be argued that offering something concrete like acupuncture which both clients and staff believe to be worthwhile might aid a person's recovery by attracting them to services, and – as some studies have suggested – helping to retain them in treatment. However, the defence of acupuncture in the absence of evidence of effectiveness would then almost certainly take us into the territory of 'placebos' – inert procedures wrapped up as medical treatments that may exert an effect, but only to the extent that patients expect or believe they will have an effect.

Any of the perceived ethical ambiguity of placebos was stripped out by a commentary published in the *American Journal of Bioethics* by Dr Alain Braillon, an alcohol treatment specialist in France[2]. Disputing their 'benign' connotations, Braillon argued that placebos fundamentally compromise the precious relationship between doctor and patient, 'strengthen medical arrogance', 'infantilise people', and 'can delay the proper diagnosis of a serious medical condition'. As he saw it,

More on treatment options at www.drinkanddrugsnews.com

Acupuncture is commonly used as a complementary therapy in the substance use field. But how effective is it, asks **Natalie Davies**

placebos were ultimately a lie.

Not coming down so harshly on placebos, the NHS website at one time reminded readers in the context of alternative and complementary therapies that 'for many health conditions, there are treatments that work better than placebos [...and by choosing] a treatment that only provides a placebo effect, [the patient] will miss out on the benefit that a better treatment would provide'. However, it stated 'improvement in a health condition due to the placebo effect is still improvement, and that is always welcome'. Interestingly, in the last few months these comments appear to have been removed.

Although acupuncture specifically has drawn protestations of 'sham procedure' and 'theatrical placebo', it has also been able to elicit a certain generosity of hope of the type that may be reserved for interventions of a transcendental nature. Furthermore, as it has fallen between the gaps of alternative and conventional therapies for treating health conditions, whether delivered in a high street clinic or mainstream healthcare space, patients absorbing the cues of the environment and culture may have found themselves yielding to something which at once seems a legitimate medical treatment *and* an ancient form of healing.

> 'Patients absorbing the cues of the environment and culture may have found themselves yielding to something which at once seems a legitimate medical treatment and an ancient form of healing.'

Shu-Ming Wang and colleagues wrote in *Anesthesia and Analgesia* that 'Instead of criticizing [the] ancient art [of acupuncture] with arguments culled from modern medicine and science, physicians and scientists should try to integrate current knowledge into this ancient, yet ever-evolving practice so it may be used to treat conditions for which pharmaceutical interventions are ineffective and/or potentially dangerous'[3].

Perhaps instead of removing acupuncture from the ambit of science as this comment suggested, it could be incorporated within the 'common factors' framework as a vehicle for delivering the essence of an effective psychosocial therapy – a credible procedure which offers an explanation for the patient's condition and a credible remedy that the patient believes in, delivered in a context which gives it the aura of a bona fide clinical treatment.

If there is not so much a 'lie' as a false impression at the heart of acupuncture, it may be that it is presented as a physical treatment rather than vehicle for the common factors found in psychosocial therapies. But without that sincerely held conviction, those common factors would be undermined and with them any benefit to be gained.

Natalie Davies is co-editor of Drug and Alcohol Findings
http://findings.org.uk/PHP/dl.php?file=acupuncture.hot&s=dd

[1] https://doi.org/10.1002/14651858.CD005192.pub2 Gates, S. (2006). Auricular acupuncture for cocaine dependence. The Cochrane Library.
[2] https://doi.org/10.1080/15265160903234078 Braillon, A. (2009). Placebo Is Far From Benign: It Is Disease-Mongering. The American Journal of Bioethics.
[3] http://www.dcscience.net/Wang-acupunc-A&A-2013.pdf Wang, SM. (2013). Acupuncture in 21st Century Anesthesia: Is There a Needle in the Haystack? Anesthesia and Analgesia.

HEALTHCARE

Seeking healthcare can be daunting for homeless people. **DDN** visits a practice in north London that takes every opportunity to engage

A FOOT IN THE DOOR

'We haven't touched the sides of the people sleeping on the streets around here. Everybody comes to Camden, they come to Euston train station, they come to Kings Cross, there are millions of tourists marching up and down Euston Road all the time. So if you want to beg, it's a good place to be.' Paul Daly is the practice manager at Camden Health Improvement Practice (CHIP), an NHS service run by Turning Point which provides health services to homeless people.

Walking from St Pancras and past Euston on the way to CHIP means navigating through people of all ages and nationalities, sitting on the street and in doorways. As a drop-in health practice, CHIP welcomes all of them without any need for ID. If you are homeless you can make your way to 108 Hampstead Road and join the morning queue.

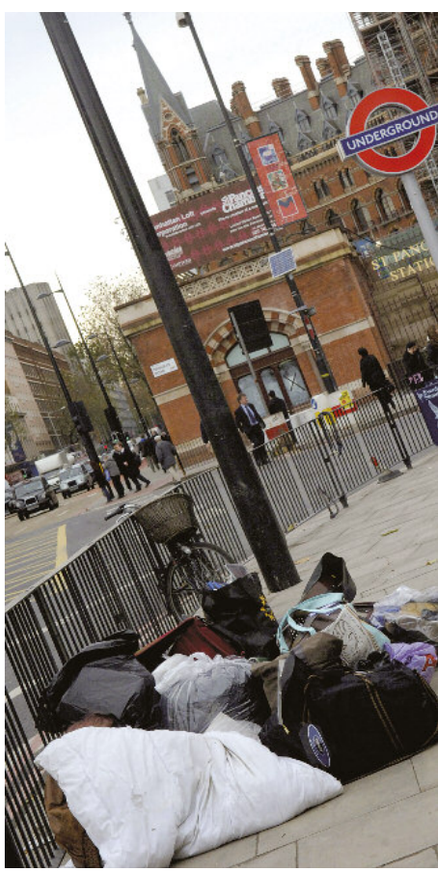
At 9.20am doors open and the first nine patients are seen by the doctor. 'That doesn't sound like a lot, but they tend to be very complex,' says Daly. If you have an emergency you can fill out a form and they will squeeze you in; otherwise you will need to turn up again the next day. Appointment slots are supposed to be 20 minutes per patient, but often run way beyond that. 'We don't restrict patients to one problem, but there's a limit to what you can do,' he says. 'Some of the patients don't present very often, so they've stored up a whole set of issues and we can't manage them all.' The practice has 800 patients at the moment – an increase of 25 per cent in the last two years.

An important routine for each new arrival is the comprehensive health check, lasting around 45 minutes, which includes tests for HIV and hepatitis B and C. This is seen as a golden opportunity to engage, explains Daly. 'A lot of these patients don't go to a GP at all – they let themselves get so ill they go straight to hospital and it's an endless cycle. So at least if they're coming in here and getting their primary care managed, they have a better chance of stopping that from happening.'

The small team has one and a half doctors and two full-time nurses. They feel very lucky to have the support of a volunteer GP who used to work at the practice and comes back twice a week to do medical reports. In common with everywhere else, budgets (and space) have been squeezed. There's no longer room for the clothing store, apart from some socks and gloves. Strong partnerships with local hostels and drop-in centres have become more important than ever.

A doctor from CHIP goes out on his bike twice a week to visit the hostels and find 'the really entrenched people' who won't come to the centre, maybe offering a prescription as an incentive to engage. Five or six years ago they were more of an outreach service, running a clinic at each hostel once a week. But it was an expensive way to run the service, needing double the staff and a lot more kit – and no guarantee that patients would be in the right place at the right time to see the clinicians.

The current model allows hostels to send their residents over to CHIP for treatment and holistic care – and the support works both ways. The area has built up a network of specialist support through its drop-ins and day centres, so there are places to refer young people, sex workers, and arrivals from other countries who might need all kinds of help. Peer support is also close at hand through the charity Groundswell, who will take people to appointments – invaluable help since funding is no longer available for the team's in-house 'navigator' post.



Steve Phillips / Jeff Gilbert / Alamy Stock Photo

‘Getting people to engage with the alcohol service is much harder than the drug service...’ PAUL DALY

More on outreach services at www.drinkanddrugsnews.com

Coming through the door at CHIP represents an opportunity. ‘A lot of the time we find you have to do everything while the patient is right there in front of you,’ says Daly. ‘The minute they go out the door, you lose them again.’ Seeing them regularly gives a chance to address longer-term health conditions – although he points out that, sadly, many patients living in the harsh environment of the streets don’t actually survive long enough to develop late middle-age conditions like diabetes and COPD.

But having them in front of you means prescribing what they need: ‘You want them to come back, and if you take a rigid approach to it they won’t come back at all. Then we can work on their other issues – it’s a different concept of medicine to a mainstream practice.’

It’s a ‘massive challenge’ for the clinicians, he adds, as making a judgement on what to do with complex cases can be really difficult. The team’s weekly meetings are a focal point for agreeing the way forward for each patient, bringing in the other services as needed, or attending multi-disciplinary meetings outside. Complex patients might need expertise from mental health, drug services, social services, police and safeguarding.

With the dialogue created around their healthcare comes access to many sources of help. A hepatology consultant visits every two weeks from the local sexual health clinic and is ‘bombarded’ with patients wanting the new hepatitis C treatment. At ‘£40,000 a throw’ triage has to operate, through assessment by a panel.

Patients also have the opportunity to see an HIV consultant who comes in every fortnight, and there is support available for mental health problems and personality disorders. Many patients are referred to the specialist alcohol service in Camden, and Daly comments that ‘getting people to engage with the alcohol service is much harder than the drug service’.

The Citizens Advice Bureau (CAB) worker comes in once a week to help with benefits and housing – and is even more in demand since the benefits system moved online. Another vital visitor is the tissue viability nurse, who comes in one a month to support the nurses and do the more complex dressings. ‘We have patients who have huge leg ulcers because they’ve been injecting for years,’ says Daly. They might come to CHIP for a while, especially if they have come out of prison, and the nurse will get the leg to a point where it’s in a good state. ‘Then they’ll disappear and turn up two months later with the same dressing on, and it’s all gone back to square one again. It looks like something from a war zone.’

Unsurprisingly, the team who run this service ‘go over and above quite a lot’, whether it’s paying for an asylum seeker’s life-saving medication while paperwork is sorted or calling in the crisis team to help a patient with a mental health issue that might take hours and ‘blow the clinic’s schedule apart’. Producing calm from chaos has become second nature to a team that focuses on stabilisation in all its contexts.

There is naturally cross-referral of patients with the drug service upstairs, but the commissioning structure does not make this as easy or logical as it could be with CHIP being commissioned by NHS England and the substance misuse service commissioned by public health.

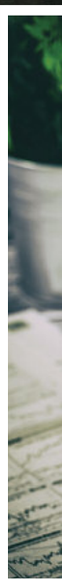
But Daly is appreciative that the CCG and medicines management team understand the nature of a homeless practice. ‘You can pay £35 just for one dressing, so our dressings budget is through the ceiling. And our antibiotics budget is a lot larger because we have a lot of infections.’ Furthermore, there are no predictable attendance patterns from one day to the next, summer or winter.

If the service was on TripAdvisor, they might have five star ratings; an equivalent endorsement would be those who still come back long after they’ve moved away. ‘People don’t want to leave us, so there are patients that have been here for 20 years,’ says Daly.

Sadly this may need to change as NHS England have told London homeless practices that nobody can stay registered with them for more than 15 months. ‘The theory is that after 15 months with us they will be cured and ready to go back to society,’ he says, ‘so you have to move everybody on, which is totally unrealistic. It was obviously written by somebody who has never come to a practice.’ **DDN**

HIGH STAKES

While a harmless diversion for many, for some people gambling can mean losing everything – even their life. With treatment provision still sparse, **Jody Lombardini** and **Danny Hames** set out how one clinic has been providing much-needed help



Recent public debate regarding fixed odds betting terminals (FOBTs), the increasing density of betting shops – particularly in more deprived areas – and the prominence of gambling advertising on television has created a much needed spotlight on the blight of gambling for many of those affected. The Gambling Commission's 2017 report indicated that 0.7 per cent of those who gambled in the past 12 months identified as problem gamblers (compared to 0.5 per cent in 2015), with 5.5 per cent identified as at-risk gamblers, and around 430,000 having a serious habit.

How many of these are individuals who also experience problems with drugs and alcohol, and do we identify this in services – even if it is an unmet need that needs highlighting to our commissioners? Gambling is an addiction, and the NHS Substance Misuse Provider Alliance (NHSSMPA) hope that extra funding is provided to increase access to treatment for those affected. Why? Because we know it can be effective – one of the NHSSMPA members, Central and North West London NHS Foundation Trust (CNWL), has long been at the forefront of providing support to gamblers. Below, Jody Lombardini shares its story on the tenth anniversary of the CNWL National Problem Gambling Clinic (NPGC).

'This country needs to acknowledge problem gambling as an illness, as an addiction...'

MAKING A DIFFERENCE

Thousands of patients have walked through the NPGC's doors over the past decade. In that time its influence has been felt far and wide, and we are very proud of it – our internationally renowned facility is still the only NHS clinic designed to treat gambling disorders. We're finding our services are required more than ever, with the numbers of people with gambling-associated problems having reached around half a million, while many millions more are impacted by the problems caused.

The clinic treats problem gamblers living in England and Wales aged 16 and over. It assesses not just their needs, but also those of their partners and family members and provides a variety of treatments. It has also served an essential function since its inception in training mental health professionals in the treatment of problem gambling.

The importance of our clinic was acknowledged by the government in June when health secretary Jeremy Hunt joined with a variety of guests in unveiling a plaque to mark its tenth anniversary. I was pleased to hear Mr Hunt acknowledge that the NHS needed to do more to help the types of patients we see, and pledge to work with Public Health England to carry out a review of services and the client group in order to inform action on how to prevent and treat this issue. I was struck by his words: 'We want to remedy this.'

The clinic was founded by consultant psychiatrist Dr Henrietta Bowden-Jones at a time when knowledge of gambling addiction was limited and support was sparse. The basic ethos was that something was needed to help people in the grip of a gambling addiction – our chief executive, Claire Murdoch, bought into this vision and has supported it ever since.

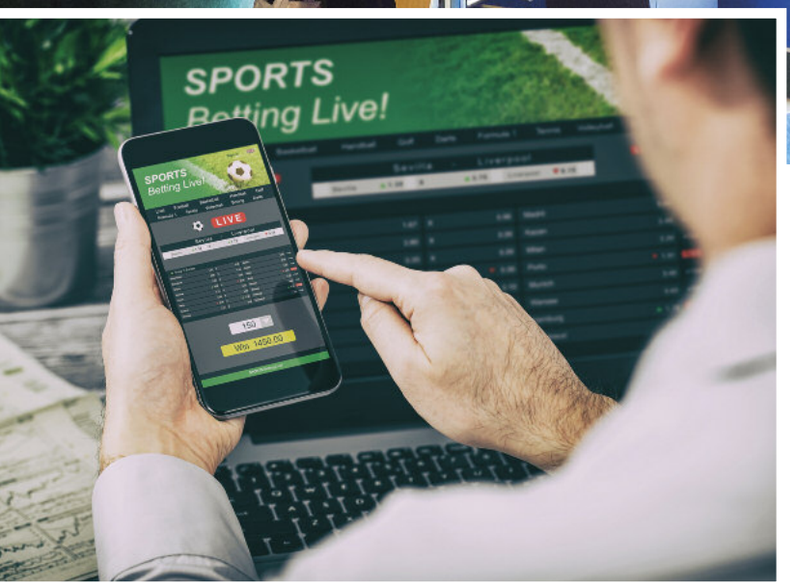
That was then, and now we have a long-term vision and hope for an expansion of dedicated services modelled on the NPGC across the country, combined with increasing awareness of problem gambling. At the unveiling of the plaque, Dr Bowden-Jones said, 'We are optimistic that the next decade will bring what we have wished for from the day we started. This country needs to acknowledge problem gambling as an illness, as an addiction just like any other. In doing so it needs to accept responsibility for the treatment of the half a million patients currently suffering from this disease.'

As CNWL's head of addictions I thoroughly endorse this vision. I have read and heard too many stories of patients whose families have been destroyed by gambling and heard too much about the numbers who have come to us having considered self-harm, or considered or attempted suicide. These are the lucky ones, however. We've all read about those who committed suicide having lost everything through gambling and had seen no way out.

We offer hope and help – both to gamblers and to their families.

Those who come to us will typically have had:

- *A lengthy period of problem gambling, with little or no abstinence*
- *Previous unsuccessful structured psychological support for problem gambling*
- *Mental health difficulties*
- *Substance misuse or other compulsive behaviours*
- *Concerns about risk of harm to self or others*
- *Serious physical health difficulties*
- *Homelessness or unstable housing or chronic social isolation*
- *Frequent involvement with the criminal justice system or history of serious offending*



- *Developmental disorders such as attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD) or difficulties with cognitive or intellectual functioning*
- *Adverse experiences in childhood.*

To be treated at CNWL's national problem gambling clinic, people can self-refer or be referred. If accepted for treatment, a proven and effective help is cognitive behavioural therapy (CBT), which is provided on an individual and group basis. Psychodynamic psychotherapy is another option and may be used with those who have failed to maintain abstinence using CBT methods, or for those who are clear that there are emotional reasons for their lapses.

With the emphasis also on the family, the clinic offers behavioural couples therapy, while another option is medication, specifically naltrexone to suppress cravings. What's clear is the gratitude of patients helped by the clinic, who through our help have managed to rebuild their lives. To mark its work, the clinic is also holding a conference at the Wellcome Collection in Euston Road on 8 October from 10am to 4pm.

The NHSSMPA behaviour change conference also takes place at the Wellcome Collection, on 17 September where CNWL will be presenting its work to delegates. For more information, or for NHS providers to find out how to be part of the alliance visit www.nhs-substance-misuse-provider-alliance.org.uk.

Jody Lombardini is head of addictions at CNWL
Danny Hames is head of development at NHSSMPA

More on problem gambling at www.drinkanddrugsnews.com

ALL BETS ARE OFF

Are Britain's betting problems getting out of hand?

GAMBLING MADE NATIONAL HEADLINES with the government's recent move to cut the maximum stake on highly controversial FOBTs from £100 to £2 (*DDN*, June, page 4), but how big is the UK's gambling problem? It's certainly large enough for PHE to launch an evidence review into its public health harms, and according to the Gambling Commission 45 per cent of people will have gambled in the last four weeks (although this includes activities like taking part in National Lottery draws or buying scratchcards). The industry's marketing budget is also huge, with betting companies spending around £150m a year on TV advertising alone – research by the BBC last year found that around 95 per cent of advertising breaks during live UK football matches had at least one gambling advert.

Using the Problem Gambling Severity Index (PGSI), 3.9 per cent of adults are categorised as 'at-risk' gamblers, while 0.8 per cent per cent of people over the age of 16 now identify as problem gamblers – defined as gambling 'to a degree that compromises, disrupts or damages family, personal or recreational pursuits'.

According to the Royal College of Psychiatrists' 2014 report, *Gambling: the hidden addiction*, the harm doesn't stop there. For every problem gambler there are between eight and ten other people who are 'directly affected' – children, friends, family members and spouses, some of whom will experience domestic violence. The same document pointed out that treatment services, funded 'almost exclusively' by the industry itself, remained largely 'underdeveloped, geographically patchy, or simply nonexistent'.

The Gambling Commission identifies the British gambling market as 'one of the most accessible' in the world, with a proliferation of betting shops on the high street and the internet bringing opportunities to gamble into 'virtually every home'. While gambling is clearly something that many people will enjoy as an occasional pastime – having 'a flutter' on the World Cup, for example – for a minority it can lead to loss of their relationship, family, job, home and even life.

Gambling participation in 2017: behaviour, awareness and attitudes at www.gamblingcommission.gov.uk
Gambling: the hidden addiction at www.rcpsych.ac.uk

scyther5 / iStock Islandstock / Alamy

NALOXONE

HIGH RISK STRATEGY

Failure to provide naloxone at the point of release for most prisoners is putting lives at risk, says **John Jolly**

Those leaving prison having had an opiate problem are seriously at risk of having a life-threatening overdose or dying as a result of one. Both Public Health England (PHE) and the government have been clear in their recommendation that all local areas need to have appropriate naloxone provision in place. However, prisons have so far failed to implement provision at the point of release across much of the estate, and this is putting lives at risk.

Blenheim workers have found that it's rare for any of our service users to be released from prison having been provided with naloxone, medication that is literally life-saving in the case of overdose. PHE's strategy to reduce drug-related deaths identifies discharge from prison as the point of maximum risk of overdose and maintaining contact with treatment services as a key intervention to stem the rise in drug-related deaths.

The NHS is responsible for provision of treatment services in prison, including naloxone, but refuses to take a national view. At one point the NHS even argued that as the prisoner would use naloxone outside of the prison it was not their responsibility, and each local authority should arrange to fund, provide, and negotiate arrangements for the supply of naloxone at the point of release. To expect them to do this with more than 100 prisons is something that anyone can see is ludicrous, but currently the NHS says it is for local NHS areas to decide.

It has proved difficult to get NHS England to provide clarity about what is going on as they are reluctant, or unable, to do so when asked. Below are a couple of replies given to questions by Grahame Morris MP that will have been prepared by officials for the government's response.

QUESTION: *To ask the secretary of state for health and social care, how many and what proportion of prisoners with a history of opioid misuse were provided with naloxone when released from prison in the latest year for which information is available; and from which prisons those prisoners were released.*

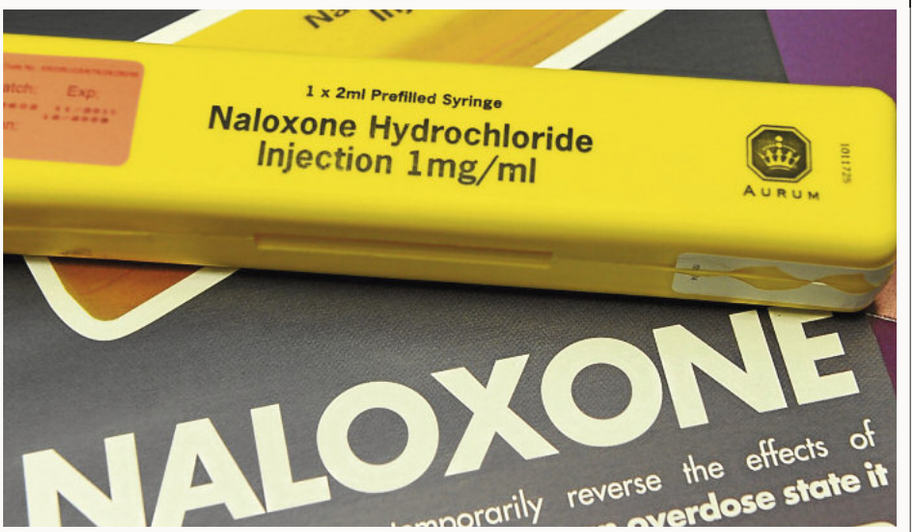
REPLY (May 2018): *Information on how many prisoners are provided with naloxone when released from prison in England is not currently available. This data is due to be published in 2019.*

'During the first week post-release, overdose deaths accounted for 85 per cent of all deaths...'

QUESTION: *To ask the secretary of state for health and social care, if he will bring forward legislative proposals to make the supply of the opioid-overdose antidote naloxone to all at-risk prisoners upon their release a mandatory requirement for prisons.*

REPLY: *Naloxone has a vital role in saving lives and the government is committed to widening its use in England. There is no national programme that mandates the supply of naloxone for at-risk prisoners on their release, and the government does not have any plans to bring forward legislation to make this a mandatory requirement for prisons. The commissioning of substance misuse treatment for prisoners is the*

More on naloxone at www.drinkanddrugsnews.com



responsibility of health and justice commissioning teams in ten of NHS England's area teams, supported by a central health and justice team. The government expects commissioners and providers of substance misuse services in prisons and in the community to work together closely in respect to prisoners being released from custody to ensure seamless transfers of care.

So according to NHS England they have not got a clue about what is happening and their best estimate is they may know in six months time. Or, as I suspect, they are putting off releasing the information and will do so for the foreseeable future. How long does it take to ask prisons the following three questions:

1) **Are you providing naloxone at point of release?**
2) **Are you providing naloxone and overdose training?**
3) **How many naloxone kits have you given out?**

Well let me try and help them out a bit. There are currently at least 36 prisons in England and Wales claiming to give out naloxone on release – a low percentage. There may also be others that I and my sources are unaware of, but just because someone at a prison says they are providing naloxone it doesn't mean they are handing out many, or any, kits. In Scotland, where all prisons are supposed to be providing naloxone at the point of release, the position is depressing – in one prison in the last year only 24 kits had been provided, while in another none had been handed out. Operational difficulties are often cited as the reason for this, a common excuse that covers most prison failures.

On the NHS website it says that NHS England health and justice teams commission to the 'principle of equivalence' which means that the health needs of a population 'constrained by their circumstances are not compromised' and that they receive an equal level of service as that offered to the rest of the population. It goes on to say that NHS England health and justice commissioning supports effective links with CCGs and local authorities to support the delivery of social care within secure settings and the 'continuity of care' as individuals move in and out of them.

Failure to provide naloxone at point of release, along with the breakdown in continuity of care – documented in response after response to the ACMD in relation to custody-to-community transitions – demonstrate a clear failure to live up to these statements. I am starting to wonder how much stigma and prejudice underlies this – I am sure diabetics requiring insulin do not suffer in the same way.

So to recap, why does naloxone at the point of release matter? A recent large scale Norwegian study[1] examined the deaths of all prisoners in the first six months of their release over a 15-year period – the sample comprised 92,663 prisoners released a total of 153,604 times, and the study found that overdose was the most common reason for death at every time period within the first six months post-release.

During the first week post-release, overdose deaths accounted for 85 per cent of all deaths, with accidents accounting for 6 per cent and suicide for 3 per cent. Overdose deaths peaked during the first days post-release, and thereafter declined gradually during the first month.

During the second week the total number of deaths approximately halved, with overdose deaths accounting for 68 per cent of all deaths. During weeks three to four and months two to six, overdose accounted for 62 per cent and 46 per cent of all deaths, respectively. For several years, Norway, like the UK, has been ranked as one of the European countries with the highest rates of overdose mortality, often explained by high rates of injecting drug use and an ageing poly-drug using population.

Recent UK research[2] also found that the first week following prison release was the period of highest risk of mortality with drug-related deaths the main cause.

By now it will come as no surprise when I say we do not have an accurate figure of the number of drug-related deaths of recently released prisoners in England and Wales. Please NHS, help sort this out and start preventing these needless deaths.

John Jolly is chief executive of Blenheim CDP

[1] **Anne Bukten, Marianne Riksheim Stavseth, Svetlana Skurtveit, Aage Tverdal, John Strang & Thomas Clausen (2017) High risk of overdose death following release from prison: variations in mortality during a 15-year observation period. Addiction volume 112, Issue 8 August 2017.**

[2] **Phillips, H. Gelsthorpe, L. & Padfield, N. (2017) Non-custodial deaths: Missing, ignored or unimportant. Criminology and Criminal Justice**

DEADLY DESIGN

THE UNEVEN PROVISION OF NALOXONE by prisons is representative of wider barriers to continuity of care from custody to community, says a new Blenheim report (see news, page 4). High death rates of opiate-dependent prisoners post-release and high dropout rates in community treatment are 'symptomatic of critical failures in the system', says *Failure by design and disinvestment: the critical state of custody-community transitions*, prepared by Russell Webster.

Funding cuts across the criminal justice system and changes to probation services mean that 'quality, supported transitions' are now the exception rather than the rule, the document states. One key area of concern is the depleted funding for the Drug Intervention Programme (DIP), which had provided the mechanism to ensure joined-up transitions, and the report urges the government to return to a 'fully funded and sustainable case management approach', along with naloxone provision for those at risk, in order to avoid further needless deaths.

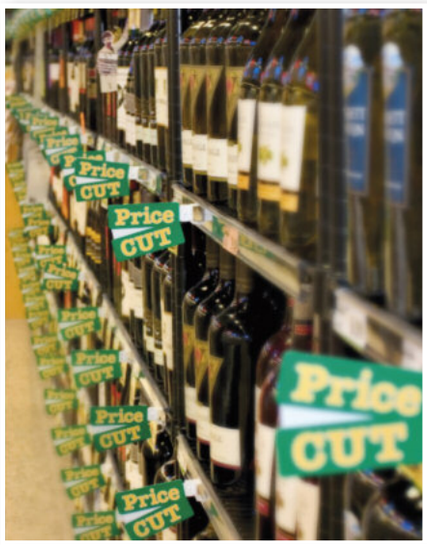
Report at blenheimcdp.org.uk

Richard Levine / Alamy Jellypics www.eveningtelegraph.co.uk

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.



'Every day in Salvation Army churches and centres we witness first-hand the damage caused by alcohol dependency...'

SIGNIFICANT STEP

I write to congratulate the National Assembly for Wales on passing the Public Health (Minimum Price for Alcohol) (Wales) Bill on 19 June. The introduction of a minimum unit price for alcohol in Wales is a significant step towards helping people around the country who struggle with alcohol misuse.

Every day in Salvation Army churches and centres we witness first-hand the damage caused by alcohol dependency to society. Alcohol misuse can have a devastating effect on our sense of self-worth and physical, mental, emotional and spiritual health. It can damage our ability to form and maintain relationships, to hold down a job, and can often lead to financial hardship, isolation and loneliness.

Since the nineteenth century, The Salvation Army has worked with women and men with problematic substance abuse. Today our support services for people who misuse alcohol include preparation, detoxification and aftercare services along with psycho-social support, education and training.

We are a long-term supporter of the Welsh Government's attempts to tackle the devastating effects of alcohol misuse on individuals and communities and have given evidence to the Health and Sports Committee about the need for a minimum unit price for alcohol.

The Salvation Army has also developed an addictions strategy for 2018-21 which sets out our clear commitment to continue to bolster the Welsh Government in its delivery of extensive social programmes helping individuals, families and communities to make positive choices about the role of alcohol in their lives.

Major Lynden Gibbs, territorial addictions officer, The Salvation Army UK and Northern Ireland Territory, London

DON'T PUT US DOWN

The 'all or nothing' article (*DDN*, April, page 12) appeared to slate people's choices of going to NA or other fellowships etc, which account for the majority of people reaching abstinence through 12 steps. It's the usual argument that people are vulnerable and newcomers preyed upon, which happens everywhere – churches, work places etc.

The 12 steps allow people who are addicts to recover the parts of themselves they have lost.

For the last 25 years abstinence has proved to be the only way for me, as someone who was a chaotic drug user and addict. Some people are just drug users, they are not addicts – there is a difference, and if they think they can successfully go and use after a period of abstinence then either they'll be back or dead, or they were never addicts in the first place.

I have watched many people, including close friends, try controlled drinking, only to see them die or use for years and struggle because of the traits of an addict – shame, pride, etc – and refuse to ask for help, which is a sad reflection on society, never mind fellowships.

NA continues to save many lives and will do forever, as we are fully self-supporting and we don't need outside money to function. No one will turn up and say your funding has come to an end, like lots of other services.

Going to a programme of complete abstinence is hard work if you still want to use, so people who don't get it then blame the fellowship instead of looking at their own patterns of behaviour. Let's keep encouraging people to find people they identify with at the level they need.

I hear these criticisms regularly but it's hard to criticise the second largest fellowship in the world when so many people not only get clean, they work through a programme to feel clean inside as well. Dealing with things from the past and amending things is a wonderful way of making sure you don't return.

Some people, and I include some of the resentful readers who emailed you, obviously have had bad experiences and, in my experience, it's usually they who cause more damage in these places.

Where else offers phone numbers to use 24 hours a day, people who open rooms freely, turn up when the support is asked for, and don't turn you away for being under the influence like lots of other services?

If anyone new read that article, it highlighted mostly negative aspects. When people see something working well they always want to bring it down. Why not try a meeting or two yourself as it's open – no secrets and definitely not a cult who chant in rooms. So please stop putting that out there – we work in co-operating with all.

Allan Houston, by email

ON COURSE?

What happened before treatment courses were available in prisons and specifically to 'lifers'? My view is simple – lifers were released without interventions of any kind. If the historical perspective is to be believed, lifers as a released group reoffended in a minority of cases. This has continued to this day.

But we do not hear this view, do we? All I'm hearing is to complete this course, then this one. I'm writing to get my view challenged – did or did not lifers get released quicker before courses hit custody with a vengeance in the early '90s. And if so, what ultimate use are the courses?

John Burns, HMP Frankland

LET'S CONNECT!

Have your say by commenting on our website, Facebook page and tweeting us

In response to 'Cracks in the mirror' (DDN, June, page 6)

Good piece, and accurate I think. Certainly in the mid North. *Kelly-Marie Nettleton*

Local authorities who hold the purse strings need to get with it and recognise the importance of outreach teams and health. *Sheila Passmore*

Our local council, it its wisdom, recently introduced a 59% funding cut for drugs/alcohol services, including outreach. *Neil Angus*

In response to 'A patient worth saving' (DDN, June, page 8)

Raised this article with my national SUI lead and my regional director. Good work, DDN. *Simon Morgan*

Nick hits nail on head – an excellent piece that we need to keep in mind.

My own education means I've concentrated on medical interventions and I am embittered by the fact that improved treatments are known but it is just too costly to introduce a new medicine if the only market is by its very nature to reduce and then withdraw its use in patient groups.

I would like to ask why dihydrocodeine seems to have been dropped. I've seen it help a LOT of people, it's cheap and it doesn't require any special licensing (as far as I am aware) so what has happened? *S W Dunlevy*

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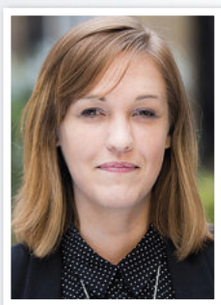
LEGAL LINE



A FEAR OF THE NEW?

Consultation has been launched on online prescribing. Take the opportunity to contribute to better understanding, says Nicole Ridgwell

The General Pharmaceutical Council (GPhC) has just launched a consultation on changes to their 2015 guidance for pharmacy services provided on the internet or at a distance. The consultation runs until 21 August 2018, and I strongly urge all such providers to contribute.

Significantly, the consultation's tone is one of concern rather than collaboration. In the introduction, it states that GPhC 'are increasingly concerned about the way some services appear to undermine the important safeguards that are in place to protect patients from accessing medicines that are not clinically appropriate for them'.

There is much of note within the consultation and providers must consider the detail to appreciate the potential consequences. For example, the consultation advises that 'a good pharmacy service will verify the patient's identity so that the medicines are right for the patient' – within itself, wholly unarguable, but how to verify? I have seen a provider criticised for not contacting a service user's NHS GP, where the service user had explicitly refused consent.

Also in the consultation, 'We believe that there are certain categories of medicines that may not be suitable to be prescribed and supplied online unless further action is taken to make sure that they are clinically appropriate for the patient'. The list includes:

- **antibiotics**
- **opiates and sedatives**
- **medicines for mental health conditions**

This would have a potentially huge (and hugely financially damaging) impact on the sector, if providers are not prepared. The consultation's timing and sector scrutiny is unsurprising. A cursory Google search brings up numerous cases in which service users died or were seriously injured after taking inappropriately prescribed medication. Many involve individuals who, for whatever reason, did not divulge their full medical history to an online prescriber. This is of course a risk with prescribing in any environment, but regulators argue that there are greater inherent safeguards in the traditional face-to-face interaction with a GP.

Providers will highlight the safeguards that have already been built into online service provision and that current criticism is more a reflection of fear of 'the new' (and the financial impact on 'the traditional') than any legitimate concern. It will always be the case that new approaches encounter suspicion and scrutiny; it is to be expected. This is not the time for the sector to stick their fingers in their ears and merely hope that regulators will learn to trust them soon.

Providers should instead treat this consultation as an opportunity; to demonstrate their willingness to engage, to explain their safeguards, to demonstrate their procedural safety and their rationales. It is the absence of understanding which is more likely to engender fear and retaliation. I therefore urge providers – take this opportunity to allow the GPhC to understand you.

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Consultation at www.pharmacyregulation.org

MEDIA SAVVY

The news, and the skews, in the national media

WHATEVER VIEW OF THE CANNABIS ISSUE IS TAKEN – and *The Independent* has always been open-minded and pragmatic in its belief – the medicinal use of cannabinoids is a narrower and more straightforward matter. Hospitals and GPs, by analogy, already make use of opioids, real and synthetic, both as painkillers and as heroin substitutes for certain addicts. It is something that is happening every day and, on balance, is something that has relieved human suffering. Even the most militantly conservative sections of opinion shouldn't challenge those. Yet cannabis oil, a far less hazardous potion than the opioids, has provoked a moral panic as only the British are capable of.

***Independent* editorial, 18 June**

THE PROBLEM with these rancorous but sterile arguments for and against legalisation and decriminalisation is that they divert attention from what should and can be done: a sustained campaign to persuade people of all ages that cannabis can send them insane.

Patrick Cockburn, *Independent*, 25 June

YOUNG PEOPLE WHO TAKE DRUGS at music festivals are only victims once they die. Until then they're criminals, and know it... To change this, all we really need to do is care about drug users before they die, rather than only afterwards.

Hugo Rifkind, *Times*, 4 June

A SMART GOVERNMENT would decriminalise milder [cannabis] variants for those over 21, and make skunk a class A drug... While decriminalisation is the policy of the Liberal Democrats and the aptly named Greens, even Jeremy Corbyn, that doyen of Glastonbury, hasn't adopted it for Labour. Legalisation will come eventually. The demographics of age make it inevitable. No one under 60 who isn't a Tory MP believes that non-skunk cannabis is a serious menace. Already, a plurality of those polled favour its licensed sale. The margin will grow with natural wastage until the electoral maths make even the *Mail*'s opposition irrelevant.

Matthew Norman, *Independent*, 3 June

FOR A GENERATION obsessed with all things ethical, isn't it unethical to buy drugs when there's so much baggage surrounding the trade?... with cocaine use on the rise in Britain – an estimated 3.6p per cent of millennials took the drug last year, well above the EU average – this is one area where young people clearly have a moral and ethical blind spot. As a millennial myself, I find my generation's complicity hard to stomach.

Tomé Morrissy-Swan, *Telegraph*, 14 June

IT IS THE THOUSANDS of selfish people, with more money than sense, who buy illegal drugs and sustain the whole great stinking heap of wickedness which they bring into being. They should be made to be ashamed of themselves, and to fear the law, made for the benefit of all, which they callously break.

Peter Hitchens, *Mail on Sunday*, 17 June