DRINK AND DRUGS NEWS

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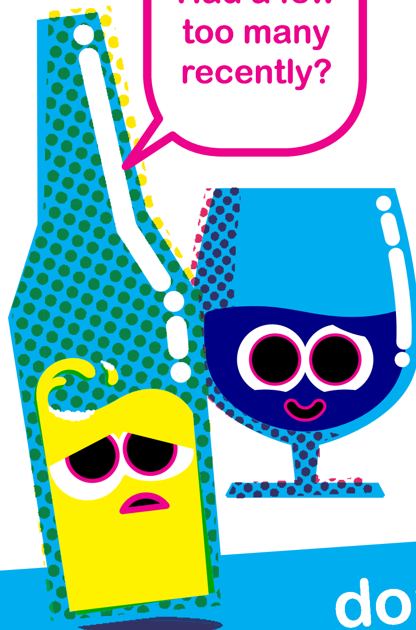

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EDITOR'S LETTER

Speakers at the DDN conference embraced the theme 'Keep on Moving'. What came out very strongly was that we need to take others along with us as we move – not just peers and colleagues, but people who are not in treatment or connected to services.

We know that many drug-related deaths are outside of treatment, and Rosanna O'Connor of PHE was among those urging us to reach out. Lord Victor Adebowale said we 'have to work together like never before' to reach those at the sharp end of the inverse care law (where those in need of health and social care the most tend to get it the least).

Mat Southwell made the strong point of calling on the treatment community to look beyond its doors to the active drug user networks, because 'when you engage with us you can interact with all those people who don't use treatment'.

Our debate session on forming a service user network acknowledged that good communication is vital if we are to get anywhere. As Radha Allen from B3 pointed out, 'chaotic drug users aren't represented in a lot of service user groups'. Throughout the conference we heard inspirational words and saw the best networking in action. We heard new ideas and real enthusiasm for joining up with others to form an active, diverse and representative network that 'agrees to disagree', in the words of Tim Sampey, and gets everybody on board.

Can we do this? We hope so at DDN, and are ready to support communications within a service user initiative. As Jacquie Johnston said, 'everyone is hardwired for connection' and this whole diverse community could be its own strongest asset.

Claire Brown, editor

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

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LOCAL AUTHORITIES FAILING TO PROVIDE SUFFICIENT NALOXONE

THE AMOUNTS OF NALOXONE BEING PROVIDED BY LOCAL COUNCILS AND PRISONS are 'extremely limited', warns a new report from Release. While all but three of the 152 local authorities who responded to Freedom of Information requests now supply the overdose-reversing medication – up from 90 per cent a year ago (*DDN*, February 2018, page 4) – the amount being dispensed is still 'drastically insufficient', says Release.

Just 16 take-home kits were provided for every 100 people using opiates in 2017-18, equating to 16 per cent coverage, with many areas also failing to provide kits to 'key populations most likely to experience or witness' an overdose. Almost 60 per cent failed to provide kits to clients accessing opioid-related treatment or services at community pharmacies, a quarter did not provide them to people in contact with outreach services for homeless populations, and more than 10 per cent failed to supply them to families and friends of people who use opioids.

While Darlington was the only local authority in England that did not report either having a take-home programme or plans to introduce one, low levels of coverage elsewhere were 'particularly shameful' given record rates of opioid-related deaths and the fact that naloxone is 'cheap to acquire and has no potential for misuse', says Release.

Many prisons were also failing to provide naloxone despite the acknowledged high risk of overdose in the first two weeks after people are released, the report says. Just over half of the 109 prisons that reported on take-home naloxone had a programme in place, and only one in five young offenders institutions. Failing to provide kits to people upon release meant that prisons were not fulfilling their duty of care, the charity states.

Release is calling for each authority to provide at least one kit to every person in the community using opiates, as well as making kits available to anyone else who requests them. People not in contact with treatment should be able to easily access naloxone through distribution points like community pharmacies, GP surgeries, ambulance services and peer networks, it adds, while every adult prison should also offer kits and training to everyone prior to release on an 'opt-out' basis.

	THN programme in place	No THN programme in place
All Prisons (109)	51% (56)	49% (53)
Female prisons [x] (12)	75% (9)	25% (3)
Male prisons (98)	49% (48)	51% (50)
YOIs (5)	20% (1)	80% (4)
HMPs (57)	46% (26)	54% (31)
HMP/YOIs (47)	62% (29)	38% (18)

Proportion of prisons in England that had a THN programme in place between September 2018 and January 2019, by category of prisons. www.release.org.uk

'There is a crisis of drug-related deaths in this country and many local authorities are failing to protect people from fatally overdosing on opioids,' said policy researcher at Release, Zoe Carre. 'The amount of take-home naloxone given out nationally has been abysmally low. This life-saving medication is not reaching those who most need it. People who use drugs are an extremely stigmatised group in society, facing significant health risks, which are exacerbated by the government's ideological abstinence-focused approach to drug use. If any other group of people were needlessly facing barriers to accessing a cheap and effective life-saving medication, there would be widespread public outrage.'

Finding a needle in a haystack: take-home naloxone in England 2017/18 at www.release.org.uk

DIVERSIONS DOWN

ILLEGAL DIVERSIONS OF DIAZEPAM FELL BY MORE THAN 70 PER CENT BETWEEN 2016 AND 2017, according to MHRA figures, with trading of zolpidem and top-strength temazepam also both down by nearly 20 per cent. 'We will continue to track down and prosecute those recklessly endangering public safety by illegally selling prescription medicines,' said MHRA head of enforcement Alastair Jeffrey. 'Those involved have no concern about your health and are making money from vulnerable people.'

'Those involved have no concern about your health and are making money from vulnerable people.' ALASTAIR JEFFREY

SHORT ODDS

NEW STANDARDS TO PROTECT CHILDREN from 'irresponsible' gambling advertising have been published by the Committee of Advertising Practice (CAP). The guidelines prohibit online gambling adverts being targeted at people 'likely to be under 18', along with the use of celebrities, sportspeople or others who are – or appear to be – under 25 as well as 'unacceptable' content that includes licensed characters from films or TV, such as certain types of animated characters. 'Playing at the margins of regulatory compliance is a gamble at the best of times, but for gambling advertisers it's particularly ill-advised, especially when the welfare of children is at stake,' said CAP director Shahriar Coupal. *Protecting children and young people – gambling guidance at www.asa.org.uk*

ADMISSIONS UP

THERE WERE 338,000 HOSPITAL ADMISSIONS in 2017-18 where the 'main cause' was a result of drinking alcohol, according to NHS Digital, a 15 per cent increase on a decade ago. People over 45 accounted for almost 70 per cent of the admissions. The figures are based on a measure where alcohol-related diseases, conditions or injuries were the primary reason for admission – using the broader measure of 'a range of other conditions that could be caused by alcohol', admission numbers rise to 1.2m. *Statistics on alcohol, England 2019 at digital.nhs.uk*

MAYORAL MOTION

A MOTION CALLING ON LONDON MAYOR SADIQ KHAN TO 'TAKE THE LEAD' on raising awareness of hepatitis C has been unanimously passed in the London Assembly. The motion was tabled by assembly member Susan Hall, who told the recent *Seven years to elimination* conference that it was 'a travesty' that hep C had not been part of the mayor's report into health inequalities (*DDN*, February, page 13). 'Tackling hepatitis C is a common-sense issue which can deliver immense improvements to quality of life for some of the most marginalised people in society, as well as huge cost savings,' said LJWG policy lead Dee Cunniffe. 'London could be the first city in the world to eliminate this deadly virus if efforts are ramped up.'

WHO DRINKS?

WHO HAS ISSUED A NEW SERIES OF FACTSHEETS on alcohol consumption and policy for 30 European countries. In 2016, more than 40 per cent of EU traffic deaths and over 20 per cent of injury deaths were the result of alcohol. *Alcohol consumption, harm and policy response fact sheets at www.who.int.*

Read the full stories, and more, online
www.drinkanddrugsnews.com

HOME OFFICE GO-AHEAD FOR PILOT DRUG-TESTING SCHEME

THE HOME OFFICE HAS GRANTED THE UK'S FIRST OFFICIAL LICENCE FOR A DRUG CHECKING SERVICE. Anyone over the age of 18 can now take a sample of their drugs to Addaction's service in Weston-super-Mare for the contents to be tested. The service is completely anonymous, with staff available to discuss support options and offer harm reduction advice.

The pilot project will operate in partnership with the University of Hertfordshire, with additional support from drug testing service The Loop. The testing process takes around ten minutes, during which people will fill in a short questionnaire to 'allow harm reduction advice to be tailored to their needs'.

Along with identifying the content of drug samples, the service will help to gain an understanding of new drug trends, identify potential sources of harm and raise alerts. Samples will not be returned to their owners.

'This is an exciting development for Addaction, the Loop and for UK harm reduction generally, resulting from several years of hard work,' said director of The Loop, Fiona Measham. 'Three summers piloting festival testing and a year piloting city centre testing has shown that drug safety testing can identify substances of concern, productively engage with service users and reduce drug-related harm.'

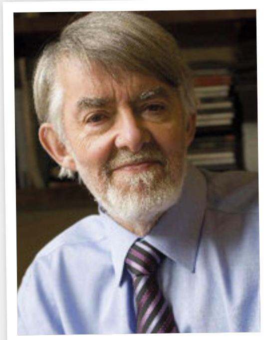
'This is about saving lives,' said Addaction's director of pharmacy, and project lead, Roz Gittins. 'We know people take drugs. We don't have to condone it but nor should we judge people or bury our heads in the sand. It's our job to do whatever we can to help people make informed choices about the risks they're taking. Checking the content of drugs is a sensible and progressive way to do that. If people know what's in something, they can be better informed about the potential harm of taking it.'

'We know people take drugs. We don't have to condone it...'

ROZ GITTINS

PAUL FLYNN

NEWPORT WEST MP PAUL FLYNN, an early and vocal advocate of drug law reform, has died aged 84. An early day motion he tabled on the Psychoactive Substances Bill stated that, 'This House regrets the depth of scientific illiteracy' in the document (*DDN*, February 2016, page 4) while he told *DDN* that the 2010 Drug Strategy was 'exactly the same as every other drug strategy – self-admiring, futile and the product of the cowardice and stupidity of politicians,' (*DDN*, June 2011, page 21). 'The adjective that has been used about me over the years is "controversial", which means that everyone agrees with every word you say years after you say it,' he added. 'It's just a question of being patient.'



'It's just a question of being patient.'

PAUL FLYNN

POLICY PROBE

AN INQUIRY INTO GOVERNMENT DRUG POLICY has been launched by the Health and Social Care Committee, with terms of reference including 'What would a high-quality, evidence-based response to drugs look like?' and 'How effective and evidence-based is treatment provision?' *Written submissions welcome until 18 March at: www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/*

CHANGING TIMES

CHANGE GROW LIVE (CGL) and its subsidiary Sova are to fully merge, the charities have announced, with the integration of both organisations' infrastructure, expertise and service delivery. Sova supports people with multiple and complex needs, and last year reported income of almost £4m, delivering more than 40 services across England and Wales. 'We've achieved a great deal under the Sova brand over the years, however this seems like the right time to work more closely with Change Grow Live,' said Sova's head of operational delivery, John Leach. 'We are making this change from a position of financial strength and this is a move that makes sense for us as an organisation as part of a strategy to have a bigger impact for the people we help.'

PRICE PROMISE

THE WELSH GOVERNMENT has committed to introducing a 50p minimum unit price for alcohol, following a public consultation. 'Ministers remain of the view that a 50p minimum unit price is a proportionate response to tackling the health risks of excessive alcohol consumption,' the government announced. It will now 'lay regulations' to the National Assembly for Wales for consideration later this year – the assembly has already supported minimum pricing when the Public Health (Minimum Price for Alcohol) (Wales) Bill was passed last year (*DDN*, July/August 2018, page 4).

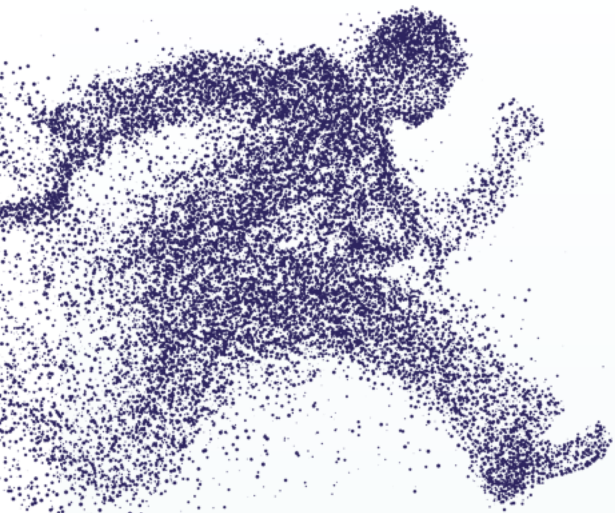
VIOLENCE REVIEW

THE GOVERNMENT HAS APPOINTED PROFESSOR DAME CAROL BLACK to lead a wide-ranging review into 'the ways in which drugs are fuelling serious violence'. Professor Black previously led the government's review looking at whether people with drug or alcohol problems should be made to undergo treatment in order to claim benefits (*DDN*, September 2015, page 4). The 'changing drugs market' has been identified by the government's serious violence strategy as a driver of recent increases in violent crime, and the review will look at 'who drug users are, what they are taking and how often' to build a comprehensive picture of the issues, the Home Office states.

RISK ASSESSMENT

AN EXPERT WORKING GROUP of the Commission on Human Medicines (CHM) is to begin a wide-ranging review into the 'benefits and risks' of opioid medicines, including dependence. 'In response to the growing concern internationally and in the UK about overuse and increased prescribing of opioid analgesics, we are seeking expert advice on the benefits and risks of opioid medicines, including best practice for risk minimisation,' said director of MHRA's vigilance and risk management of medicines division, Dr June Raine.

Session 1



MOVING FORWARD

The day's first session focused the current state of play in the treatment sector, the vital role of user involvement, and where things needed to go from here. Photography by *Nigel Brunsdon*

'I feel as though I'm among friends,' Turning Point chief executive Lord Victor Adebowale told delegates at *Keep on Moving*'s opening session, 'Food for thought'.

'The theme of this conference is *Keep on Moving*, but before we talk about the future I think it's worth reflecting on the past – where we've come from.' When he'd become chief executive in 2001 Tony Blair was still prime minister and drug and alcohol treatment were 'quite separate', he told delegates, with 'huge debates' about what service structures should look like.

The New Labour government had a focus on evidence-based research, he said, with 200 targets for every government department. Although the first ten-year drug strategy talked about diversion into treatment from criminal justice, the focus was still on 'crime reduction rather than harm reduction', he stressed. 'The emphasis was on getting problem drug users into treatment, and enhancing the quality of that treatment by setting targets.'

The numbers in treatment – and spending on treatment – increased dramatically. Since then, however, public health had moved to local government from the NHS, with seven out of ten councils cutting their spending on drug and alcohol treatment. Among the councils that had reduced their spending, 83 per cent had seen an increase in drug-related deaths, he pointed out.

Today around 58 per cent of treatment was provided by third sector organisations compared to just 42 per cent by the NHS, and Turning Point had grown by adapting and working with communities, he said. 'The majority of services are now provided by the not-for-profit sector, which brings me to service user involvement. As far as I'm concerned, I'm talking to fellow professionals. The people that you work with trust you – as you have trusted people – with their lives. It's not just about being an ex-user or someone in recovery.'

Austerity had not gone away and Brexit was 'not going to help', he said. The conditions and challenges that pushed people 'to the edge', such as money worries, lack of job security, stress, poor housing and family breakdown, were getting worse, and tackling those issues needed professionals with experience. 'We can't cut our way into the future,' he stated. 'We have to work with others. To tackle these issues in the context of reducing resources we need professionalism and partnerships with our communities.

'I want to thank you because, fundamentally, every single person sitting in this room makes people like me look good,' he continued. 'You're the people with frontline understanding. In the next five years the challenges we face now are going to become more acute, and we're going to have to work differently, not just harder, in a way that's "and/and" rather than "either/or".'

As drug and alcohol treatment had been separate in 2001, now substance misuse was separate from the rest of the NHS, he said. 'I see people who have

'The conditions and challenges that push people to the edge, such as money worries, lack of job security, stress, poor housing and family breakdown, are getting worse, and tackling those issues needs professionals with experience.'
LORD VICTOR ADEBOWALE

> 'There is no place for a drug user to engage from a policy point of view – people who don't want to use services.'
> *Stephen Malloy*

health challenges presenting with substance misuse challenges and I know we could do more for them in one place, but we have to move them on.'

What was needed were integrated services that could do more for clients in the same place, he stated. 'We support people with complex needs, that's the issue, and we need to do that in a way that's both integrated and that responds to the simple fact that we're working with people at the sharp end of the inverse care law – that those in need of health and social care the most tend to get it the least. We have to keep moving forward because, frankly, we have no choice. Your professionalism and your understanding of substance misuse is done on behalf of the people who aren't in this room, and we have to work together like never before. We don't have a choice but to keep on moving.'

The numbers of people accessing alcohol treatment had fallen by 19 per cent over three years, Public Health England's (PHE) director of alcohol, drugs and tobacco, Rosanna O'Connor told delegates – from 65,000 to just over 52,000. This was compared to only a 5 per cent fall in numbers entering treatment for other substances. 'It's a significant fall and one we're taking a lot of notice of. Only one in five of those who need treatment for their alcohol use are actually getting it,' she said, and that trend would continue unless local areas ensured that their strategic and commissioning plans, service specifications and referral pathways were able to meet the need.

Nearly all services were now commissioned as drug and alcohol services together, she said. 'There's something about the way those services are operating that appears to make it more difficult for people to get in if they have an alcohol problem.' PHE would be distributing £6m next year, with a focus on asking local authorities to develop and deliver plans for improving access to alcohol treatment.

Homelessness had also become an 'alarmingly obvious' and visible problem, she said, with the numbers of rough sleepers in England up by 165 per cent since 2010, and more than half of all deaths of homeless people the result of drugs. 'We are working very closely with other departments and with NHS England towards a vision of halving rough sleeping by 2022 and ending it by 2027.'

Mental health was another crucial issue, with up to 70 per cent of drug service users and 86 per cent of alcohol services users experiencing mental health problems. Information on whether a person starting treatment had reported a mental health need was now being recorded for the first time, she said, and PHE had published guidance on better care for people with co-occurring mental health and alcohol and drug use conditions. 'We know there's a gap and we're working with government partners on how to close that gap,' she said. 'It's obvious that we should be working better together to reduce harm and enhance recovery.'

While smoking prevalence in England was now very low, at around 15 per cent, among people with mental health problems it was three times that, while 59 per cent of opiate clients were smokers when they started treatment. 'There's a myth that it's impossible to address someone's smoking if you're also addressing their drug and alcohol use. We are supporting the development of effective treatment programmes to help people in drug and alcohol services to stop smoking.'

Drug-related deaths remained high, she said, and many were among people in their 40s and 50s. Heroin-related deaths 'not surprisingly' continued to make up the largest proportion, with the highest rates in the North East and Yorkshire and Humber. PHE had published guidance and tailored support to what was happening at local level, she said. 'A lot of these drug-related deaths are of people who aren't in treatment – reaching out to these people is something that we should all be doing.'

> 'It's important that your voice is heard and helps to shape policy and practice in the future. It's important... that we have opportunities to listen and learn from you. I can only half do my job if I'm not being influenced by what are your real experiences.'
> ROSANNA O'CONNOR

Session 1

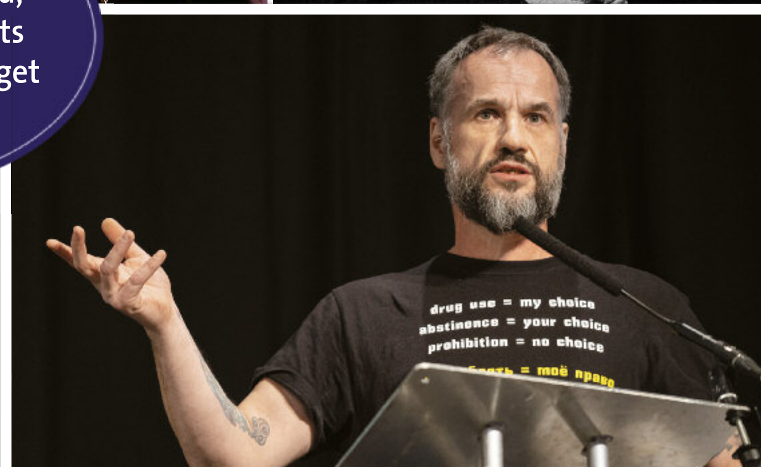
'I try so hard to get service users involved, but no one ever wants to know. So how do I get them involved?'

Gary, delegate

PHE was also providing guidance on the wider provision of naloxone, including mapping the adequate provision of nasal naloxone. Her organisation had issued guidance outlining four different levels of service user involvement for commissioners and providers, she said – involvement in people's own care and treatment plans, involvement in strategic development and commissioning, developing peer mentoring and support, and delivering user-led, recovery-focused services. Injecting drug use continued to be the highest risk factor for hepatitis C, she stated, and to meet the NHS' 2025 eradication target would need local authorities, drug services and the NHS to all work together. 'Treatment needs to be available where people who use drugs are,' she said, and drug services should be using peer support to encourage and promote testing and treatment.

PHE would be pressing the government's recently launched Carol Black review into drugs and violence (see news, page 5) to look at how the drug treatment sector is able to meet this range of challenges, she said, while the sector also needed to make the most of the opportunities presented by the increasing focus on mental health in the NHS.

'Your voice is really important,' she told delegates, 'and it's important that your voice is heard and helps to shape policy and practice in the future. It's important at a local level and it's important at a national level that we have opportunities to listen to you and learn from you. I can only half do my job if I'm not being influenced by what are your real experiences.'



The role of people who use drugs was back at the heart of harm reduction, drug user advocate and activist Mat Southwell told the conference. 'I don't think there's been a space to discuss harm reduction in the UK, and I'm disgusted that it's taken an HIV outbreak in Glasgow to bring the focus back.' Post-Brexit, drug-related deaths in Europe were predicted to fall by 25 per cent 'simply because we're leaving', he said. 'There are older drug users in the UK, yes, but that's also the case across Europe. We've got back to where we used to be, with people going to treatment as a last resort because of the pressure to come off drugs. Methadone is not something people should be pushed off, unless they're ready to change.'

The government was putting ideology and scapegoating above science and human rights, he said. 'This ridiculous review looking at violence and drugs will not be looking at prohibition – it's like having a review of obesity and not looking at sugar. When you start undermining people's rights the logical end point is drug users being murdered, as they are in places like the Philippines.'

Service user activism could have huge impact, he said, with the 'White Noise' movement in Georgia seeing 10,000 people marching against the country's harsh police crackdown on drug users. INPUD was engaging the UN, EuroNPUD was engaging the EU and country drug user groups were engaging national governments, he said, with examples of peer-led harm reduction worldwide including needle patrols, secondary NSP programmes, peer education and peer-led distribution of naloxone. 'When you bias everything around service user involvement towards recovery then you lose all of this. We need to get angry, and I'm unapologetic about standing up here being pissed off.' The disproportionate costs of prohibition 'far outweigh any benefits that people claim', he said.

'You have a responsibility when you work with a drug user network that, as well as power, we have vulnerabilities,' he said. 'When you engage us we can interact with all those people who don't use treatment. Treatment is part of the care pathway, but it's not the whole care pathway.

'It's time to reorganise,' he told the conference. ' We want to help our peers. Stop framing us as a problem. Let's be part of the solution.'

'Treatment is part of the care pathway, but it's not the whole care pathway... It's time to reorganise. We want to help our peers. Stop framing us as a problem. Let's be part of the solution.'

MAT SOUTHWELL

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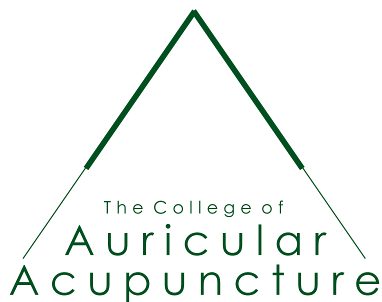

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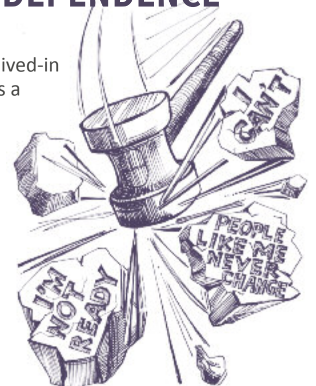

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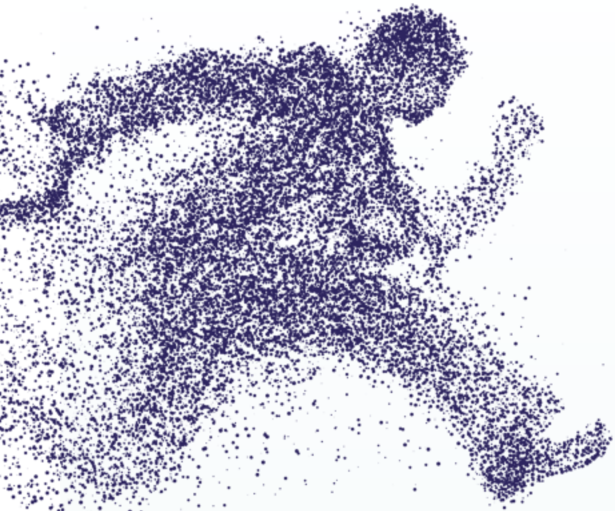
THE SPECIALISTS IN ATTITUDE CHANGE

Session 2



TALKING IT THROUGH

The morning's second session, 'The Big Conversation', focused on the shape of service user involvement and how it should look in the future

The aim of the day's second session was to take a detailed look at service user involvement – why it's needed and where it's going, as well as whether a national service user network could be created that would be representative, relevant to today's needs, and able to bring renewed purpose and direction.

'We're quite a big organisation, we go the length and breadth of the country – we've had a certain amount of success but it's quite challenging,' said national service user lead for CGL, Mark Pryke. 'Service users in different parts of the country will meet different challenges because of different local authority policies and so on. One hat does not fit all – you need to see the need and the person, and then start thinking about what you're going to do.'

Misinterpretation, misinformation, and people not getting the right message could create more problems than 'you set off with', he told the conference. His organisation was in the process of having an open dialogue with service user reps, with more than 80 coming to regional events to share their views. 'We've had whole days based around participation and we asked people to be honest about how they felt. We're getting non-loaded information, and all of that information will influence our future plans. As an organisation we're not perfect – we're too big to be perfect – but if we're working in the right direction, with the right people, at the right time, we can get a lot done.' There was a 'massive need' for services to start connecting, he told the conference. 'Let's get a network and take it from there.'

In the early days of Build on Belief (BoB), meetings used to be 'a riot', said its CEO Tim Sampey. 'It was a proper tear-up, but what came out of that was organisations like B3 and BoB. So in one respect it was very successful, but in another it was a disaster because it was dogmatic and we couldn't talk to each other.'

This meant opportunities had been wasted, he stated. 'I'm so tired of death – I know so many people who've died that I can't remember all their names and faces, and I do think we need a national service user voice. But if we're going to do this, can we agree to disagree before we start talking? Because we need everybody – abstinence, harm reduction, the LGBT community, the BAME community. If we can't get everybody on board then it's a waste of time.'

The voice of the service user wasn't just important, it was vital, said director of Dear Albert, Jon Roberts. 'No matter where we sit on the spectrum, the common thread is that service user involvement is an absolutely vital component of treatment, of recovery, of harm reduction. For many, involvement *is* recovery and we need to see treatment providers offering more opportunities for that. Recovery, moving on and having a more meaningful life means that person being able to use that organisation as a climbing frame.' While he'd been somewhat sceptical in the past about a national service user voice, maybe 'the time is right', he said.

Service users in Wandsworth sat on interview panels and attended strategic meetings, said service user involvement coordinator for Wandsworth Council, Rosy Flexer. However, she did have some concerns that involvement had 'been hijacked a bit by the recovery agenda. Sometimes service users are meant to feel privileged to attend strategic meetings, rather than feel it's their right.' The word 'consultation', meanwhile, could often mean 'telling service users what's happening then going away and doing it anyway'.

'In order for us to function well together we need to copy what a lot of gay men living with HIV/Aids did with the AIDS Coalition to Unleash Power (ACT UP)' said delegate Andrea Efthimiou-Mordaunt. 'They had caucuses, so if we had a national user network we could have a BAME caucus, a lesbian and gay caucus, a radical feminist caucus, a trans caucus – whatever it was that people needed.' Once core issues had been agreed on, 'we could come back to a general assembly to push things forward', she said.

However, if it was common knowledge that the majority of people dying were those outside services, did that mean service user groups were 'not truly representing the views of drug users living in communities,' asked delegate Stephen Molloy. 'Do service user groups hold services to account? We're seeing the

'We're beyond service user involvement – it's about service user leadership. Everybody's got skills – it's not hard to spot a leader.'
Peter Yarwood, Red Rose Recovery

highest number of deaths we've ever seen, and yet people are talking about yoga and therapeutic approaches, or whatever it may be. Is there any engagement around what's happening in the streets to people? What exactly is the point if it's not representing the needs of everyone in the community, not just the people accessing that service?'

Service users did need to be developing forums that reached out to people not in treatment, agreed Release executive director Niamh Eastwood. 'But it's also the human rights of people in treatment that are being diminished in many parts of the country,' with conditionality linked to methadone scripts, people being 'coerced' into treatment or having their doses reduced. 'Quality treatment is needed in every area, and I think a national network could help push that,' she said.

Collective Voice would be 'really supportive' of a national network, said its director, Oliver Standing, whether 'it's service users or people who use drugs,' while Jon Roberts added that, 'We don't want to disenfranchise the majority of people who might be using drugs but who are not in treatment. We're shifting from service user involvement, so called, to peer-led interventions and creating communities that can reach out to anybody. The landscape is definitely changing – you can bolt skill sets onto the right attitude with people who want to give back, but it's a lot harder to bolt an attitude onto a skill set.'

'Service users in different parts of the country meet different challenges because of different local authority policies... There is a massive need for services to start connecting. Let's get a network and take it from there.'
MARK PRYKE

'We're way past service user involvement,' Red Rose Recovery CEO Peter Yarwood told the session. 'We're having conversations about service user leadership. Everybody's got skills – it's not hard to pick out a leader, whether they're in treatment or out of it, whether they're in active addiction or abstinence-based recovery. It's easy to spot a leader and create opportunities for them to have a go and get involved. If we're not bringing people in active addiction with us on this journey, we're missing a massive asset of people who have privileged access to the very communities we need to be tapping into. I don't know what we'd call it, but there's definitely a need for a network on a national scale.' This could also then be used to influence and apply pressure at local level, he stressed.

'We don't know about the needs of the people we never meet,' said session chair Carole Sharma. 'Providers imagine they know what's going on in the drugs environment they serve, but they may be very wrong', while B3 service manager Radha Allen added that, 'chaotic drug users aren't represented in a lot of service user groups'.

Part of the network's function could be to hold providers to account, said Carole Sharma, along with using experience to improve services and drive policy change. When people were not engaging with services, there were 'reasons for that', she said. 'You have the drug strategy, but no one joins anything up – with childcare, looking after elderly people, homelessness, everything that's going wrong. I was very angry when drug and alcohol management went to local authorities. I'm sorry, but I don't trust local authorities with something that's as difficult and complex as this, and the public health budget is just getting whittled away. The new ten-year NHS plan is saying prevention and public health is where it's at, but they're taking the money away. So for that reason alone I'd say that you really need to get your act together locally.'

When it came to influencing policy, the last drug strategy 'reads beautifully, but it's absolutely full of shit because no one has the money to implement it', said Tim Sampey. 'What's the point of writing a policy that nobody can stick to? We need to be in a position to point that out, but we're not.'

WHAT IS SUBSTANCE MISUSE TREATMENT FOR?

MangoStar_Studio / iStock

As deputy drug czar for the Blair government, **Mike Trace** oversaw the expansion of today's drug and alcohol treatment system. In the third of his series of articles, he gives his personal view of the successes and failures of the past 20 years, and the challenges the sector now faces.

In my last article, I summarised what I think have been the achievements, and failures, of the substance misuse sector over the last 20 years. One of the disappointments is that the sector has not facilitated a higher rate of recovery – helping more people to make transformational changes to the circumstances and behaviours that led them into drug and alcohol problems. The sector argues endlessly about definitions of recovery, and how best to enable people to find it, but I think we can all agree that we should be helping people to move from chaos and dependence to self-control, self-respect and independence.

The reason I started work in this sector 30 years ago was to help people who had been dealt a poor hand in life to confront the emotional and economic hardships they had endured, resolve to overcome them, and build a new life. That remains my reason for going to work. And observing the courage and determination of people going through that journey, and their joy in finding recovery, is my main job satisfaction.

So it amazes me that the sector does not focus more on this function – of inspiring and supporting transformational change. All drug and alcohol services are called recovery now – but my experience is that too much of what they do is neither inspirational nor ambitious for clients. Funding and performance management systems too often seem to encourage this focus on delivering basic care and case management processes, with not enough focus on the human factors that inspire change – organisations can win contracts to provide millions of pounds worth of services without demonstrating (or even describing) how they will help people to become independent.

The National Treatment Agency (NTA) blew its last chance to create the right incentives for a more recovery-oriented system. It created the national Key Performance Indicator around the number of people leaving treatment and not returning within a specified time. I said at the time that this is just another measure of our own processes, not of an individual's real personal development. The aggregation of these sort of proxy indicators tells us little about a service's real effectiveness, just the nature of its record keeping. But it is currently the main measure that is used to judge a service's recovery credentials.

So real recovery – changes in attitudes and lifestyle – is not systematically embedded into, and incentivised within, our system. It is left to the initiative of good projects and good people (those projects that welcome, inspire, support and affirm – and fill their environment with positive, ambitious messages for clients, and role models and mentors to show what is possible). A great development in recent years has been the growth of peer-led recovery networks and communities. These are essential elements of a local treatment system, but it is shameful to see how little of the available funding goes to them, and most I speak to these days are struggling to grow.

Where this lack of vision and ambition exists, it not only misses opportunities for clients to show their potential, it creates a 'system' problem – if we have 270,000 people in treatment, hundreds of thousands more who should be in treatment, and around 120,000 new entrants per year, we need to have many more than the current 50,000 leaving the system per year (meaningfully leaving, not just ducking in and out) to make the numbers sustainable. In the absence of more effective move on/recovery, the treatment sector 'bucket' overflows and quality suffers in an overextended system.

> 'All drug and alcohol services are called recovery now – but my experience is that too much of what they do is neither inspirational nor ambitious for clients.'

In a context of an overall reduction in resources, this problem is acute – I will use my next article to suggest some ways out of this downward spiral.

Mike Trace is CEO of Forward Trust

More legal advice at:
www.drinkanddrugsnews.com

The devil is in the detail

Hope Davis-McCallion examines CQC's new draft guidance on factual accuracy process – and the main changes for providers

It has been nearly two years since the CQC last issued guidance on their factual accuracy process. During this time, it has been noticeable to providers and solicitors who work in this field that inspectors tire of parts of the guidance. It should come as no surprise then that CQC have issued new draft guidance for all providers on the process. But, have they improved the process for providers or simply changed it to make their lives easier?

Published earlier this year, the 'factual accuracy checking process' has been updated to allow providers to:

- challenge any information that is factually incorrect
- tell CQC where their evidence in the report may be incomplete

This reasoning isn't too dissimilar from their guidance issued in 2017, but closer inspection shows there are several changes within the draft guidance which providers need to be aware of. As the saying goes, the devil is in the detail.

The main changes have been summarised below:

01 **Instead of being sent a Word document to complete the factual accuracy check, CQC will send an email to the appropriate registered person and this will include a copy of the draft report and a link to download a form to provide a response. CQC say they 'will not usually accept factual accuracy comments in any other format'. Providers need to be aware of this and ensure they tell CQC immediately if they cannot respond using the form.**

02 **If any evidence is sent to support sections B and C of the document, providers must specify the page and paragraph number and highlight the exact wording in the document that is relevant to the point you are making. This point is particularly important as if this is not made clear, the inspector will need to ask the provider for it and if it's not provided then CQC have the powers to not consider the evidence further.**

03 **Providers can send CQC information about action they have taken since the inspection that 'addresses the concerns we raised with you, or which is included in the draft report'. It is then within CQC's powers to decide whether to include this new information in the final report. However, most importantly, unless there are exceptional circumstances, this new information will not form part of the final judgments or ratings.**

04 **Despite CQC previously allowing it, providers are not allowed to ask to see the inspector's notes from an inspection or details of people the inspectors spoke with – a highly controversial issue to say the least. Inspection notes and details of people the inspectors spoke with form the main reasoning behind the draft inspection report. Why then, are providers not allowed to see CQC's main evidence behind the justification for the report and ratings? Ridouts would still challenge for notes under the relevant statutory provisions where they are pertinent to questions of reliability.**

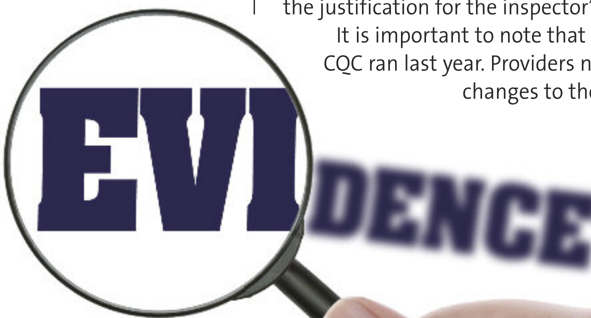
05 **Providers cannot ask CQC for information about workers who have reported concerns to them due to confidentiality.**

The above changes may seem small, but in practice could be onerous and taxing for the provider. For example, it will be a burdensome task specifying the details of the evidence referred to in the report, and one that can only benefit the person reading it.

It is purely at CQC's discretion whether new information about action taken since the inspection will be included in the report. However, in the interest of the provider, will CQC explain the reasoning as to why they have or, more importantly, have not included the information?

As already mentioned, the exclusion of the inspector's notes and details of the people the inspectors spoke to stops the provider from really understanding the justification for the inspector's report and rating.

It is important to note that this is draft guidance following a consultation CQC ran last year. Providers need to keep a careful check on this and the changes to the process. It is imperative that providers challenge inspection reports where they dispute the findings, ensuring that the report is accurate and gives a proper and true reflection at the time of the inspection.



Hope Davis-McCallion is a solicitor at Ridouts, a specialist law firm that has a core expertise in health and social care law, www.ridout-law.com

It is imperative that providers challenge inspection reports where they dispute the findings.

Session 3

'We are really fortunate in Lancashire in that as service users we really do feel that we've got a voice, and that we're listened to.'

Liz, LUF

INSIGHTFUL STORIES

The day's final session, 'Insights', heard personal stories about naloxone, the lack of support for problem gambling, and properly engaging with your past to move on in the future

'I was a heavy-duty heroin and crack user for 20 years,' Alex Boyt told the day's closing session. 'I haven't used drugs for 15 years, but I don't see myself as in recovery.'

He'd first learned about naloxone at Harm Reduction International's 2008 conference in Barcelona, he said. 'In those days, the governance around naloxone was crazy. At one point you could only be prescribed it to use on yourself, when you're unconscious. It was that kind of crazy thinking that really made provision difficult in the early days.'

An early naloxone exercise in Chicago had seen the drug-using community 'saturated' with the medication, with around 80,000 doses given out to 40,000 injecting drug users. Drug-related deaths then fell by around 25 per cent.

However, half of all overdoses occurred while people were alone, he said, meaning that naloxone would be no help.

'So naloxone is significant, but it's not a magic bullet. Drug-related deaths are at record levels, and if you look at a map of them and a map of deprivation they pretty much match each other. What causes drug-related deaths is misery and deprivation, so we really need to bear that in mind.' What was also frustrating was that there were no known negative effects to naloxone, he added.

'My personal story is that I'd done my second prison sentence – I'd been in there for a year', which included taking various relapse-prevention courses. On leaving, however, the 'first thing I did was go to score. I bought a bit of heroin, was very careful with the first hit, but with the second I was less careful.' He'd woken up with paramedics standing over him – they'd given him naloxone, and 'it did save my life.' Provision had now improved significantly, and although it wasn't a magic bullet it was 'a really vital part of how communities take care of each other', he stressed.

'Back in the day if you went over you'd get rushed to hospital and be given naloxone,' said CGL recovery worker Peter Hawley. 'My passion of really trying to drive use of naloxone is that over the years I've seen pals and service users be there one minute and overdosed the next.'

He'd got into service user involvement in East Sussex, training staff, distributing naloxone to a wider audience and 'being part of the national drive', he said. By September 2018 CGL had dispensed more than 29,000 kits through community pharmacies, with more than 1,500 being used in overdose situations.

'When we started our penetration rate was really, really low, so I really pushed it,' he said. 'I got the whole service to really embrace it,' and now more than 90 per cent of service users were supplied with naloxone. 'But I was still thinking of the

'Naloxone is significant, but it's not a magic bullet. Drug-related deaths are at record levels, and if you look at a map of them and a map of deprivation they pretty much match each other. What causes drug-related deaths is misery and deprivation'

ALEX BOYT

bigger picture and who else I could get on board.'

The East Sussex naloxone working group now included CGL directors, a PHE consultant, a safer communities board lead, CCG commissioners, pharmacy leads and high ranking police officers, among others, he told delegates. The main pathways he was hoping the group would embrace were police custody, dispensing pharmacies, police as first responders, A&E departments, general hospitals, mental health wards and ambulance crews. 'The law has just changed and now we're exploring nasal naloxone, which hopefully will be a driver for change,' he said.

'Imagine the person next to you has been on a massive alcohol binge and has drunk in excess of a bottle of vodka a day,' gambling harm consultant Owen Baily told delegates. 'Consider how they might be feeling and behaving. Imagine someone who has been on a crack binge for weeks, how they might appear to you right now. Then imagine someone who's been gambling all the money they have, they haven't paid their rent or bought food – consider how they might be behaving.'

Problem gamblers displayed few behavioural indicators, despite causing great harm to themselves, he said, and it was this capacity for problematic gambling to be concealed that led to it being called the 'silent' addiction. 'I'm calling on the drug and alcohol treatment sector to do more to at every level to be just that little bit more curious about gambling,' he said, while in terms of service user involvement, Twitter was a powerful platform that could be used to drive things forward.

'This time last year I was heading towards the worst life crisis I'd ever

experienced in my adult life,' he told the conference. 'I was suicidal and I'm very fortunate that I'm not dead or in prison. I'm not saying that to be dramatic, I'm saying it as a matter of fact.'

He grew up in a single-parent household and experienced emotional bullying from his mother's boyfriend, later getting into drugs. 'I'd become feral, but it wasn't without consequence.' He was permanently excluded from school, became homeless, and was later in a young offenders' institution and a bail hostel. 'I discovered morals and values and an appreciation of my liberty, having had it taken away.'

He then discovered 'just how safe it felt to play fruit machines', he said. 'I cultivated very unhealthy thoughts and beliefs around gambling,' and experiencing a first 'big win' made him go on to gamble even more. He gave up his home and job to go travelling, only to instantly gamble his money away, arriving back in the UK homeless and destitute. 'For want of a better phrase, I was fucked,' he said.

Realising he had a serious problem he looked for help in the local area, but found there was nothing. He began to drink heavily and became alcohol-dependent – 'now I had my ticket to access local service provision', he said, beginning a 16-year treatment journey. 'I went to rehab for drink and drugs, but my gambling was mocked and ridiculed.' Later, he began to attend a local Gamblers Anonymous service and then the National Problem Gambling Clinic operated by the Central and North West London NHS Foundation Trust – the only NHS clinic for the treatment of gambling disorders.

The East Sussex naloxone working group now includes CGL directors, a PHE consultant, a safer communities board lead, CCG commissioners, pharmacy leads and high ranking police officers.

PETER HAWLEY

Session 3

> 'I'm calling on the drug and alcohol treatment sector to do more to at every level to be just that little bit more curious about gambling.'
>
> OWEN BAILY

'I found what I was looking for – a short and very intense practical intervention.' Although he went on to relapse a couple of years later, what was important was that 'I'd managed to achieve a period where I'd stayed stopped for the first time.'

Accessing targeted help had been 'quite a journey', he said. 'If you use substances you're far better off in terms of access to treatment. With gambling it very much depends on where you live.' All gambling treatment organisations received funding indirectly from the gambling industry, he pointed out.

In recent years, Fixed Odds Betting Terminals (FOBTs) had brought a 'hard' form of gambling onto the high street and generated considerable controversy, while gambling advertising had also started to proliferate. However, a public health-based review of gambling harms had been announced and the NHS was now looking at how it could improve access to treatment.

'Despite a bad start in life, today I'm in a very good place in my recovery. As I look forward I see a bright and fulfilling future, and I'm incredibly passionate about putting my experience of gambling-related harm to positive use.' Services could display details of help on notice boards, hold meetings and appoint a person in each service as a gambling rep, he said. 'Let's carry on talking and see what we can do to improve knowledge, understanding and awareness around gambling-related harm.'

The day closed with a presentation from Jacquie Johnston, on the theme of moving forward through knowing what's driving you from your past. As a little girl she had been 'innocent and excitable', but had no idea what her life was going to look like, she said. She'd been inseparable from her brother, mainly through fear – 'my dad was a raging binge-drinking alky, and a regular perpetrator of domestic violence. We'd sit and listen to mum and dad fight.'

The shame of having a failed marriage meant her mother stayed in the situation for years, but 'during one of their worst-ever fights I managed as a nine-year-old to phone the police and we got out that night in just the clothes we stood up in'. However, her mother by now had 'lost her spirit' and become alcohol-dependent.

As her mother was 'drunk or absent most of the time' she had to take on the role of 'mini-mum' to her brother, she said. By this time, however, her life had also 'taken a turn – a path of sexual abuse, truanting, violence, self-harm, suicide attempts, neglect', she said, followed by foster care, detention centres, mental health wards and hospital. 'While all that had a huge impact on my life, I still had my brother.'

He also took the father role with her young sons, as 'because history often repeats itself I went on to marry an alcoholic gambler when I was 17'. Her brother's life, however, was tragically cut short when he was killed by a drunk driver in 1992. 'My whole life changed. My eldest son was 12 and he also tried to take his own life as a result

'We'd like to tell you about what's happening about service user involvement in Wales – absolutely nothing. Being a recovery champion is not service user involvement.'
Rondine Molinaro, Kaleidoscope Project

of losing his father figure. But I made a commitment on the day of his funeral that his life wouldn't be in vain and that I'd turn my pain into purpose.'

It took some years to work out how, but she took a leadership course and went on to develop the Brink in Liverpool – the UK's first recovery bar – and set up the country's first recovery choir, the Raucous Caucus Recovery Chorus. She also developed Sharp Liverpool, which was the first abstinence-based day centre in Merseyside, as well as the first candle-light vigil to remember people lost to addiction and the first UK recovery walk. Her most recent role had been at Tom Harrison House, the UK's first addiction treatment centre exclusively for military veterans.

'Along the way, I started to get recognition and won a series of awards. While it's nice to be honoured, for me awards have to be about the leverage of the project.' As she moved on she began to have a 'real understanding of "what else is there? How come I need to look back to change the future?" Not to camp out in the past and be miserable, but to understand what happened there, and how come it's still driving things today.'

Einstein had once been asked what was the most important question, she said, and his answer was whether the universe was a friendly place. 'It's all based on how you see the world,' she told delegates. 'If Mother Teresa and Charles Manson were in here they'd have a different perspective of what's going on. For me, regardless of what my life has looked like, I have a choice and I want the universe to be a friendly place. I don't want to be working in organisations that are always fearful and worrying where the money's coming from – I don't want that any more.'

Everyone was born 'hardwired for connection', she said. 'When a child feels connection is being cut from them, they get scared. Everybody has something that's happened to them that's caused something painful – there's no league table of traumas, it's about the impact it has on you.'

An 'SOS' arose from early trauma, she said – 'suspicion of self'. Pain led people to 'never want to feel that again', and develop strategies to move on. 'The subject of this conference is moving on, but now I want to do that in a healthy way. So many workers in the system have never even paid attention to their own pain, so they're bringing that in and projecting their own stuff onto people who come into a service.'

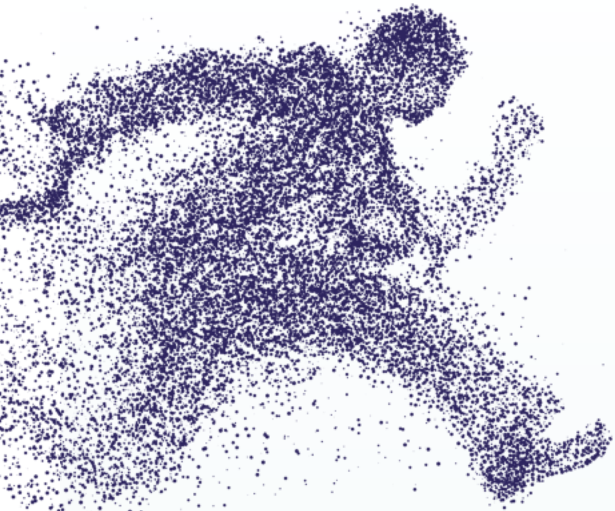
People would 'hide, pretend, and defend', she said. 'We don't even know sometimes that these strategies are masks. For me, the good news is the way out of getting out of being stuck in your own patterns is through reaching your own vulnerability. Those other strategies won't work out – the vulnerability will always be kinder and more gentle with people. It's difficult, because we're frightened that we'll be taken advantage of, but I want to be emotionally responsible.'

The art of vulnerable communication meant reflecting on feelings, she said. 'Tell your truth but stay curious – your perceptions may be different but maybe you can find some common ground. Be accountable for your behaviour, and be transparent. Three words allow me to focus on who I am – love, leadership and legacy. So in everything, I ask myself is this the best I can do?'

Her new role was with Vitality Homes, she said, developing a 17-bed recovery living community with ten move-on flats. 'There's loads of opposition. All the local residents are in uproar, so I have to remember "love, leadership and legacy", otherwise I'll revert to type and want to go in there and scrap with them. I correct the self-belief that I'm a dangerous liability. As you move forward, remember to look behind you. Discover your own story, and see how it plays out today.'

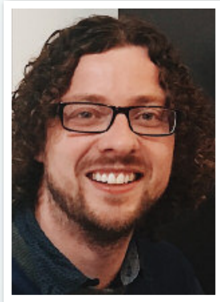
'When a child feels connection is being cut from them, they get scared. Everybody has something that's happened to them that's caused something painful – there's no league table of traumas, it's about the impact it has on you.'
JACQUIE JOHNSTON

Voices



A NEED TO BE HEARD

The voice of service users speaks louder than ever, says *Paul North*



A lot has changed in drug treatment in the past 20 years. Countless contracts have come and gone, entire providers have gone out of business, several drug strategies have significantly changed the focus of treatment, and funding has plummeted. Among this flux one thing has always remained of vital importance; the voice of service users needs hearing.

The best way to connect with this voice is to attend DDN's annual conference, 'Keep on Moving' – this year's title correctly suggesting that a level of resilience is required for anyone passionate about this space. In the morning Tim Sampey's 'Big Conversation' talk summed it up well when he said, 'I am really tired of death. I know so many people who have died, I can't even remember all their names and faces'.

Yet, despite the tiredness and countless drug-related deaths, he continues to run an inspiring weekend-based mutual aid service in London called Build On Belief. And Tim is not alone in this resilience and commitment to advocating for the rights of service users. Comments throughout the day highlighted the passion that exists for service user involvement and the need for it to remain at the forefront of delivery.

Despite the passion, attending the conference gave me the impression that everyone in the sector is feeling frustrated. The cuts to treatment services have been nothing short of brutal, with little investment from government, even in the context of record levels of drug-related deaths. Mat Southwell from the European Network of People who Use Drugs (EuroNPUD) gave a fantastic presentation, which was full of difficult questions for those in government.

'How on earth have we had an outbreak of HIV in 2018 in Glasgow, the home of harm reduction?, he asked. A good question, the answer to which is likely to lie in the lack of investment and funding in the sector. He also asked, why is the UK seeing so many drug-related deaths compared to other parts of Europe? He stated that it can't just be due to an ageing population, highlighting that changes to the way in which treatment services work could play a key role.

Despite the latest government drug strategy referencing the importance of harm reduction it sounds as though treatment services are still heavily monitored on drug-free outcomes. Several comments were made throughout the day with members of the audience stating that if treatment services didn't

Reflections on the DDN Conference

There are a few themes that arise when we speak of the DDN conference and our experience over the last six years. Lancashire User Forum (LUF) organise for around 30 delegates, who are at different stages of their journey, to attend every year. It has become one of our highlights and our guys begin to rally round for places in early January. Attending the conference is refreshing – it gives the people of Lancashire an appreciation of the bigger picture from a national perspective and an opportunity to link in with peers across the UK. Every year we bring down fresh faces and each one has an amazing experience. One of the main themes to emerge after a DDN conference is the power of connection; people realising that resources lie within relationships is powerful, and that's what the DDN conference is all about for us – a great big, fat networking opportunity! A chance for our people to get motivated and share best practice, bringing new ideas back with us.

This year we brought down some family members from our newly formed Families Matter support network. They didn't really know what to expect and were a bit apprehensive about attending – however after some persuasion from Emma and me they packed an overnight bag and came along for the ride! The feedback from the families was that they didn't really understand what we did here in Lancashire, but after attending the conference they loved it and are fired up to make a difference for family members, It's not about the numbers or how big the group is, but rather the belief and passion of the people driving the change.

Peter Yarwood and Emma Daggers, Red Rose Recovery

> ‘We need a service user voice. We have access to people – but not the infrastructure to get to them. We’re too busy trying to keep people alive.’
> *Tim Sampey, BoB*

> ‘The common point today is that service user involvement is absolutely vital. It gives a sense of hope and belonging.’
> *Jon Roberts, Dear Albert*

pressure people to stop taking drugs so much, more people would attend for support.

On several occasions the question was asked ‘how do we make sure those who don’t access services are represented?’. This is an important question, especially considering most drug-related deaths are among those who are not in treatment services. As pointed out by Rosanna O’Connor, director for alcohol, drugs and tobacco at Public Health England, alcohol presentations in drug treatment have reduced by 19 per cent in three years, which is significant when you consider all other drugs have dropped by just 5 per cent.

Alongside the tension and frustrations there’s no doubt there was a great deal of passion and commitment at the conference. The afternoon session felt far more personal, with speakers sharing their own stories and experiences of drug use. There is a great amount of positivity around service user involvement, despite the pressures treatment is under and it is inspiring to hear of the hard work which is taking place across the country to support service users in treatment.

The voice of service users is more important than ever, and the conference highlighted both the great work and the clear frustrations which exist. On the way back down to London I spent a lot of time reflecting on Tim’s quote, trying to remember all the names and faces of the people I knew who died in nine years whilst working in treatment. Like Tim, I couldn’t remember them all and the process of reflecting was tiring, difficult and draining. Yet it reminded me how important this issue is, and spending a day surrounded by people who, despite the sadness, won’t ever stop championing for service users was, and always is, a privilege.

Paul North is director of external affairs at Volteface and tweets at @Paul__North

The ARC (Ayriss Recovery Coventry CIC) attended the DDN conference and found the day really insightful. We met some great people from different organisations, made some new contacts, offered support and received advice, and learnt about new initiatives and products available. As a small organisation that was only formed in October 2018, this is massively vital in making connections with like-minded services.

The guest speakers were really passionate and enthusiastic and it was a delight to see people driven by topics like harm reduction. Everyone got a chance to get involved and ask questions and join in.

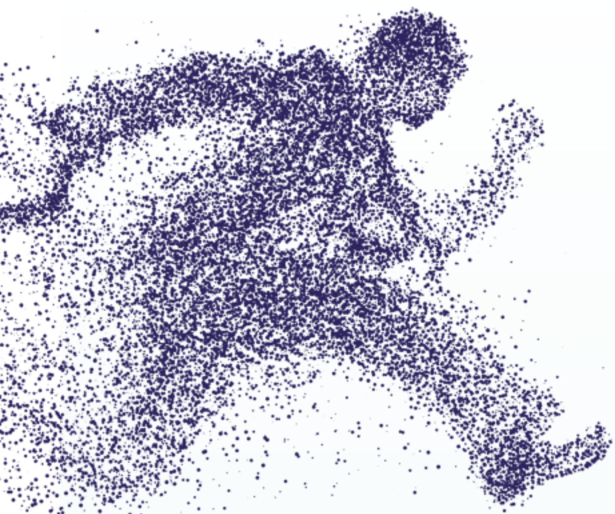
It was a really fantastic day and we look forward to coming again next year.

Louise, The Arc (Ayriss Recovery Coventry CIC)

This was my second DDN conference. I met some thoroughly interesting people, had a fun day, and the programme of speakers was excellent. We heard about the importance of service user involvement and groups, improvements in the distribution of naloxone, new gambling addiction support, experience of making a short film, and much more. The most inspiring was ‘An open heart’ by Jacquie Johnston, who shared her personal story, I felt privileged to hear it. Such a worthwhile get together – thanks DDN. I recommend you experience a DDN conference.

Helen Hayden, service manager Harrow and newsletter editor, Build on Belief

Voices



'A national network could push things forward in every area. We would be happy to support it.'
Niamh Eastwood, Release

DDN would like to say a big

thank you

to everyone who supported 'Keep on Moving'!

Our sponsors – **Camurus**, **Martindale Pharma**, **Nal Von Minden** and **PHE**. All of the organisations who exhibited and supported delegates' attendance. All of our excellent speakers and panellists, and debate chair **Carole Sharma**.

Nigel Brunsdon – www.nigelbrunsdon.com – for his photography. **Paolo Sedazzari** for filming the event – see the films at www.drinkanddrugsnews.com

Our volunteers – the teams from **Changes UK Recovery Academy** and **CGL Coventry**, **Lee Collingham** and **Marcus Wolf**. **Samantha Lofthouse** and **Lois Skilleter of Earthereal of Yorkshire** for taster therapies.

... **and all of our wonderful delegates**. See you next year!

'We talk about empowering people, but we expect service users to come and give the information for nothing, at their own expense. People in government wouldn't go to work if they weren't being paid, but for peers that's what's expected.'
Lee Collingham, delegate

Reflections on the DDN conference

Here we are at the DDN conference at the Build on Belief stand – Linda Rose and Rob Demacque, managers from Ealing. We were there with the new BoB IOS (Information, Opportunities, Support) phone. This was used to show many of the activities we engage in at BoB in Ealing and at our other projects.

We had enormous fun meeting other service providers and getting to know about them and what is on offer for those with drug and alcohol issues. As the theme of the conference was 'Keep on Moving', we discussed how service users can have a collective voice, be heard, and more importantly be listened to about what is needed from services to help recovery.

Unfortunately funding is always an issue and is not going to improve any time soon, so the opportunity to get ideas and swap tips was invaluable. We both came back buzzing with new ideas to enhance our service in Ealing.
Linda Rose and Rob Demacque, managers, Build on Belief Ealing

This was my first ever DDN conference and I really enjoyed it. It was so interesting meeting other services across the country and getting an insight into what they do. The panel discussion was brilliant and the lunch after was really good.

All in all it was a great day out from start to finish and I would definitely like to come again.

I think the highlight for me was learning about the Recovery Street Film Festival in September, to which I hope to organise a day trip with service users.
Sam Taylor, service manager, Build on Belief Harrow

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www.drinkanddrugsnews.com

CLINICAL EYE

A QUESTION OF VALUE

Nurses should be a highly prized asset in every addiction service, says **Ishbel Straker**

IN A MONTH'S TIME I AM DUE TO REVALIDATE WITH THE NURSING AND MIDWIFERY COUNCIL (NMC). It was three years ago since I last did this, and what a lot has happened in this time.

Revalidation, similar to the appraisal process for doctors, is not only a regulatory requirement, it is also an opportunity to reflect on past practice and future purpose. This is invaluable and something that is significantly enhanced by the professional acting in the role of confirmer (appraiser).

In all my roles as a senior nurse I have been part of this process on behalf of nurses who worked within my services – and ensured that within the organisations I had responsibility for, I highlighted this process of compliance and ensured it was adhered to.

This is the role of a senior nurse – not just to support the organisation with its compliance, but most importantly to support the nurses. Within the addiction field over the past three years I have watched organisations value and devalue nurses, realising their need and then removing this due to a focus on expense over quality – and then subsequently complaining that there are issues with recruitment!

'Nurses have become the fat that can be trimmed from organisations for a quick 'book-keeping' win, without a thought for the care of the patients.'

Nurses have become the fat that can be trimmed from organisations for a quick 'book-keeping' win, without a thought for the care of the patients. In recent conversations with a CQC inspector I discussed why this seems to be the case and concluded that this occurs so frequently because those who are doing the trimming have no investment or understanding of the profession and see it as an easily replaceable job.

This I feel is due to the quality of nurses within the addiction field who make the job look so easy, who get on with the role without complaint and who have trained to take on multiple roles within this sphere, making the job look 'easy'.

So, what's the answer? Well for a start, organisations need to recognise that nurses have value and that the training we undertake enables us to take on multiple roles within substance misuse services with exceptional ability. Regardless of whether this role appears to be able to be done by non-nurses, I would vehemently argue the case against devaluing this highly skilled profession.

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

MEDIA SAVVY

The news, and the skews, in the national media

'Moderation has been rebranded as middle of the road, a cop-out. Dry January is a panacea for the worried well...'

THE MOVEMENT FOR MODERATION IN ALL THINGS HAS GIVEN WAY TO EXCLUSION ZONES, to the virtuous circle of cutting out, amputating, becoming free from. Conflicting messages on whether a glass of red wine is good or bad for you leave us feeling that not drinking at all is the route to eternal life. This purge mentality is not new – it has its roots in fasting and hair shirts. Banishing harm or pleasure from our lives is a form of self-control when everything else is chaotic and not susceptible to individual influence. Moderation has been rebranded as middle of the road, a cop-out. Dry January is a panacea for the worried well, a form of hypochondria.
Linda Grant, *Guardian*, 4 February

THE NUMBER OF PEOPLE DRINKING ABOVE THE CHIEF MEDICAL OFFICER'S GUIDELINES TELLS US NOTHING about how many people are drinking at a dangerous level. This should come as no surprise. We know that the chief medical officer's guidelines do not reflect the risks of drinking. We might also conclude that there are no benefits to be had from reducing alcohol consumption unless it is the heaviest drinkers who are cutting down. No purpose is served by getting moderate drinkers to become light drinkers, nor by getting light drinkers to become teetotallers. This might seem obvious, but much that is obvious is denied by the philosopher kings of 'public health' academia.
Christopher Snowdon, *Spectator*, 8 February

THERE ARE THOSE WHO CALL FOR A SURRENDER IN THE WAR ON DRUGS. This isn't going to happen. Nor should it. Cocaine, like alcohol, and unlike heroin or marijuana, has no recognised therapeutic role. Society has a clear and legitimate interest in discouraging its use. The war on drugs must be fought, but like most wars it causes most casualties among non-combatants. The strategic objective is not so much the capture of occasional kingpins, but minimising the harm they, and their products, do to their customers, whether by addiction or incarceration.
***Guardian* editorial, 13 February**

THIS COUNTRY IS NOW PAYING A VERY HEAVY PRICE FOR FAILING TO ENFORCE ITS LAWS AGAINST MARIJUANA for more than 40 years. Its use, though not general, is horribly widespread and we now have a hard core of regular users, visible early in wrecked schooling, later in broken, hopeless lives, unemployable husks of humans begging in shop doorways, a grief to their families and a charge on the state, and in many cases confined to the locked wards of mental hospitals. But it is sometimes worse than that. What we also see, if we look, is that the culprits of a startling number of crazy, violent offences, here and abroad, were cannabis users.
Peter Hitchens, *Mail on Sunday*, 3 February

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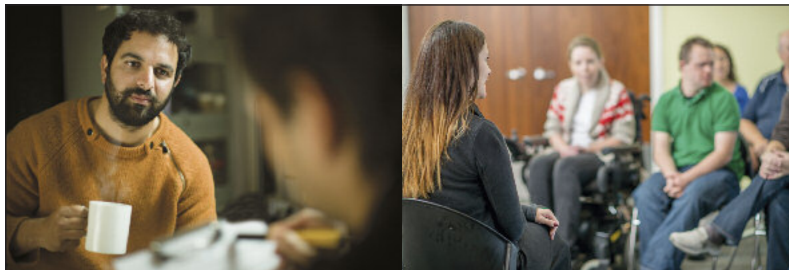

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