DRINK AND DRUGS NEWS

DDN

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FACING THE FACTS

IT'S TIME TO CHALLENGE STIGMATISING LANGUAGE ON SOCIAL MEDIA

INSIDE: Words of advice for the new recovery champion

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EDITOR'S LETTER

pic: nigelbrunsdon.com

Back in 2010, the UK Drug Policy Commission analysed newspaper coverage and produced a report, *Representations of Drug use and drug users in the British Press*. It highlighted negative reporting, condemnatory attitudes and pejorative labelling, and contributed to some valuable work around stigma, including the guide for journalists that the UKDPC's former CEO Roger Howard mentions in his piece on page 14.

Since then, the presence of social media has been a complete game changer. As James Armstrong explores in our cover story (page 6), online stigma can all too often 'go viral' with the coveted social media reward of getting attention. While we can't control the internet, what we can do is encourage those with first-hand experience to tell their stories, breaking down the polarisation of 'us and them'.

The internet is shaping every area of our work and Kevin Flemen gives invaluable insight to what's happening on the 'darknet'. International policing operations may be enjoying successes in closing down online market places – but have we thought about the impact on the UK drugs scene? Are such operations feeding customers to dealer networks and county lines gangs? And, crucially, will the quality of drugs suffer, with all the implications for compromised safety?

We hope you have a good summer as we go into the break – the new issue will be out on 9 September. In the meantime keep in touch with your contributions and feedback – we'll be here!

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

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'BIASED' CLASSIFICATION FUELLING DRUG PROBLEM, SAYS COMMISSION

BIASED HISTORICAL CLASSIFICATION OF PSYCHOACTIVE SUBSTANCES has been a significant contribution to the world drug problem, according to a report from the Global Commission on Drug Policy (GCDP).

While drug classification remains the 'cornerstone' of the UN Conventions underpinning international drug control, it continues to be influenced by ideology, political gains and commercial interests, says *Classification of psychoactive substances: when science was left behind*.

The international classification of drugs now has little or no correlation to scientifically assessed harms and needs to be 'urgently reviewed', the document states. While drugs should be classed according to their potential for dependence and other harm this is 'not the case today', it says. The fact that substances such as alcohol are 'culturally important' means they are legally available, while the strict prohibition of others leads to 'tragic consequences' such as executions, organised crime and the spread of blood-borne viruses.

The international community needs to recognise the 'incoherence and inconsistencies' in the drug scheduling system, it says, and launch a critical review. The commission is calling on governments to ensure that their classification systems are pragmatic and based on science and evidence, and also allow for 'responsible legal regulatory models' to control drugs.

'The international system to classify drugs is at the core of the drug control regime – unfortunately that core is rotten,' said GCDP chair and former president of Switzerland, Ruth Dreifuss. 'Some drugs were evaluated up to eight decades ago – which does not represent current knowledge – and others have never been evaluated.'

Report at www.globalcommissionondrugs.org

'The international system to classify drugs is at the core of the drug control regime – unfortunately that core is rotten'

RUTH DREIFUSS

Professor Chris Whitty has been appointed as the new chief medical officer for England

WHITTY OFFICER

Professor Chris Whitty has been appointed as the new chief medical officer for England, the government has announced. Professor Whitty is currently chief scientific advisor for the Department of Health and Social Care (DHSC) and professor of public and international health at the London School of Hygiene and Tropical Medicine. He replaces Dame Sally Davies, who oversaw the introduction of strict new alcohol guidelines of 14 units a week for both men and women (*DDN*, February 2016, page 4).

TRIPLE THREAT

THE NUMBER OF PEOPLE aged over 40 in treatment for opiate use has tripled in little over a decade, according to ACMD. The number has risen from approximately 25,000 in 2006 to more than 75,000 last year. However, the number of under-30s in opiate treatment has fallen from around 60,000 to just 13,000 over the same period. 'This ageing cohort is likely to dominate future demand on substance misuse facilities, which is why more needs to be done now to help these people access services that meet their needs,' said ACMD chair Dr Owen Bowden-Jones. 'Government, commissioners and services need to urgently re-assess how to best manage the complex needs of this ageing group.' *Ageing cohort of drug users at www.gov.uk*

DEADLY PRODUCT

ALMOST ONE IN FIVE PREMATURE DEATHS from non-communicable diseases in the European region – where nearly 210m people smoke – could be avoided by eliminating tobacco use, according to a WHO report. This includes 90 per cent of lung cancers, says *European tobacco use – trends report 2019*. 'There is a huge potential to improve health by implementing policies that we know are effective, such as increasing taxation, using plain packaging, banning advertising and eliminating exposure to second-hand smoke,' said WHO Europe's programme manager for tobacco control, Kristina Mauer-Stender. *Report at www.euro.who.int*

PREVALENT PROBLEMS

SIXTY PER CENT OF BRITISH PEOPLE know someone with an addiction problem, according to a YouGov survey commissioned by Action on Addiction. More than two thirds also believe there should be more support for people with substance issues, and 70 per cent that there should be more support for their families. 'This poll highlights the widespread and far-reaching impact of addiction,' said Action on Addiction chief executive Graham Beech. 'Unfortunately, this comes at a time when society's ability to address the problems associated with addiction is diminishing and people are finding it more and more difficult to access the treatment they need.'

STUBBED OUT

BEVERLY HILLS CITY COUNCIL in California has voted unanimously to prohibit the sale of all tobacco products from January 2021. Although hotels will continue to be able to sell tobacco to guests, all other businesses will be subject to the ruling, making it the most restrictive tobacco ban in the US.

LANGUAGE MATTERS

JOURNALISTS NEED TO ADD 'DEPTH AND NUANCE' to their reporting of drugs issues, says a report from Phoenix Futures and Pulsar. This could include making it clear that 'not all drugs are the same' and expanding on the 'environmental context in which problematic drug use thrives', such as social exclusion, homelessness and poor mental health. Social media users also need to remember the effects that stigmatising language can have, says *Care to share: social media conversation about addiction, recovery and stigma*, which studied almost 200,000 public messages from Twitter, online forums and blog channels between December 2018 and January 2019. 'Whilst we do not wish to police the use of language, we urge people to consider the potential negative impact of language on vulnerable people,' it states. *Report at www.phoenix-futures.org.uk*.

See feature, page 6

PRISON SAFETY UNDER THREAT FROM RISING NPS USE

THE RISE IN NPS USE IN PRISONS HAS HAD A SERIOUS IMPACT ON SAFETY, with increasing rates of violence and self-harm, says the annual report of the Independent Monitoring Boards (IMB). As well as their impact on health and behaviour, drugs have produced an 'alternative power structure, based on debt, bullying and intimidation of prisoners, their families and sometimes prison staff', the document states.

The prison system in England and Wales is now in a state of 'fragile recovery' following a lengthy period of increased drug use and violence combined with staffing problems and inadequate rehabilitation opportunities, it says. While some new measures such as the government's prison drug strategy (*DDN*, May, page 4) were showing 'signs of promise', it was too early to say if they would have any sustained impact, said IMB chair Dame Anne Owers. There were also significant concerns around the number of prisoners with serious mental health conditions who were being held for lengthy periods in prison segregation units.

Every prison has an IMB, with boards across 'all kinds' expressing serious concern about the availability of drugs, particularly NPS. HMP Guys Marsh in Dorset saw an average of one NPS-related incident per day last year, while HMP Humber had an average of ten per week in 2017. In one month at HMP Wayland 41 prisoners were under the influence of NPS, of whom 26 self-harmed and five needed to be taken to hospital. At HMP The Mount in Hertfordshire, a drug recovery wing had to be shut down because there were 'too many drugs' – when it was moved to another wing, 'the drugs, bullying and violence moved with it'.

Incidents of reported violence have also increased in 'every part' of the closed prison estate, the report notes, from local prisons to high security establishments. Boards in almost all local prisons had reported significant rises in violence and assaults, and rates had doubled in Bedford, Belmarsh, Durham and Wandsworth. Birmingham, meanwhile, had 'stabilised' at the level of 120 assaults per month.

'There is no question that IMBs are still reporting some serious and ongoing problems in prisons,' said Dame Anne Owers. 'The decline in safety, conditions and purposeful activity in prisons over the last few years has seriously hampered their ability to rehabilitate prisoners. This will take time to reverse, and will require consistent leadership and management both in the Prison Service and the Ministry of Justice, as new staff, policies and resources bed in.'

IMB national annual report 2017/18 at www.imb.org.uk

'There is no question that IMBs are still reporting some serious and on-going problems in prisons'

DAME ANNE OWERS

LABELLING LAWS

ALCOHOL LABELLING that includes up-to-date drinking guidelines would be mandatory under a Labour government, according to shadow health secretary Jonathan Ashworth. Despite being introduced three and a half years ago as of last year only 16 per cent of people were aware of the government's revised low-risk drinking guidelines (*DDN*, February 2018, page 5), with many products still referring to outdated limits or having no guideline information at all. 'It's an utter abdication of responsibility for government to task the chief medical officer with updating the guidelines and then not oblige the industry to display this vital information on their products,' Ashworth stated.

'Abdication of responsibility...'

JONATHAN ASHWORTH

FRIDAY FAILINGS

THE UK'S PRISON SERVICES should take steps to avoid releasing prisoners with complex needs on a Friday afternoon, says a report from ACMD. More than a third of prisoners are released on Fridays, which makes it more difficult for them to access drug treatment or stable housing, says *Custody-community transitions*. It also increases the risk of relapse or overdose, which is particularly high in the first weeks after release. In 2017-18, just 12 per cent of prisoners with an opioid problem left prison with naloxone, while more than a third of prisoners were released without settled accommodation. 'It is paramount that the government makes sure more is done to help prevent vulnerable people from relapsing after their release from prison,' said ACMD chair Dr Owen Bowden-Jones. *Report at www.gov.uk*

SEIZING UP

EUROPE IS SEEING RECORD LEVELS OF SEIZURES of cocaine, says the latest *EMCDDA European drug report*. Both the number of seizures and the quantities seized are at record levels, with more than 140 tonnes seized in 2017 – double the previous year's total. Fifty-five new NPS were also detected for the first time in 2018, bringing the total number being monitored by EMCDDA to 730. *European drug report 2019: trends and developments at www.emcdda.europa.eu*

HALF MEASURES

A REPORT FROM THE MONITORING AND EVALUATING SCOTLAND'S ALCOHOL STRATEGY programme (MESAS) shows that the percentage of alcohol sold below 50p per unit in Scottish off-licences and supermarkets last year was half that sold in 2017. Minimum pricing of 50p per unit was finally introduced in Scotland last May, following a lengthy legal battle. Last year also saw the lowest total volume of pure alcohol sold per adult in Scotland since records began in the mid-'90s, at 9.9 litres per week. However, this still remains almost 10 per cent higher than figures for England and Wales.

2019 MESAS monitoring report at www.healthscotland.scot/

WELCOME HELP

THE COUNTRY'S FIRST NHS GAMBLING CLINIC for children is to open this year, NHS England has announced. According to the Gambling Commission, around 55,000 children can be classed as having a gambling problem, while 450,000 are regular gamblers – a higher number than those who have drunk alcohol or taken drugs (*DDN*, December/January, page 5). The facility will form part of a growing network of services for people with gambling issues, including the establishment of up to 14 new clinics.'This has the potential to be a major turning point and it is all about making sure the NHS does everything it can to help people of all ages who are seriously addicted to gambling,' said NHS England's national director for mental health, Claire Murdoch.

ANOTHER STORY

Social media is full of stigmatising language about drug use. We should be using powerful first-person stories to create a more positive picture, says **James Armstrong**

As a charity Phoenix has been actively using social media for around eight years. It offers us an opportunity to share knowledge and experience about drugs and alcohol away from the sometimes suspect agenda – or poorly informed opinions – found within more traditional forms of media. Over this time, we've developed a highly engaged group of followers and friends, and a compassionate community of support.

However, none of us need spend long on social media before we encounter what inventor of the world wide web Tim Berners-Lee described on its 30th anniversary as the 'unintended negative consequences of [the web's] benevolent design, such as the outraged and polarised tone and quality of online discourse'.

Often the online discourse on drugs and alcohol is prompted by news stories that set the tone for outrage and conflict. Just as angry and provocative headlines stir the emotions of the public in order to sell papers, there can be a similarly attention-seeking approach online. It's hard to shake the underlying feeling that this polarised online discourse of anger and outrage is driven by stigma. So in response to this, late last year we started to think about how we could shed light on the stigma that is at the root of how drugs and alcohol are presented in British social media, and how having a clearer idea of this could ultimately help the sector combat it effectively.

There are various types of stigma, and all create barriers to treatment and support. We know that self-stigma breeds feelings of guilt and shame in people who need help and delays their accessing of treatment, so prolonging harm and suffering for them and their loved ones. Societal stigma, meanwhile, limits access to resources such as funding for treatment, access to jobs, homes and social engagement, and structural stigma influences the multiple social policies that discriminate against the people who use our services and their families.

Stigma has the potential to invade all forms of social interaction because it exists, perhaps unconsciously, in the minds of so many people. However, people's minds can be changed if we start to understand how the feelings and attitudes that lead to stigma are formed.

Stigma can be seen as a mental short cut. It bypasses nuanced understanding of complex issues and, upon hearing the word

'As people learn more they are less likely to blame... and more likely to seek an understanding of the complex social drivers of the harms of addiction...'

More on tackling stigma at:
www.drinkanddrugsnews.com

'drugs', leads our thought processes directly to a sense of threat and danger. This creates social distancing between the stigmatiser and the stigmatised, and contributes towards the dehumanisation of the latter, painting them as something to be feared. We all, to some extent, fear what we do not understand. People with little or no experience of drug and alcohol issues have no other information to draw on to temper their fear, and are therefore particularly susceptible to this mental short cut.

The notion of attribution error tells us that people tend to unduly emphasise other people's character, rather than external factors, when explaining their behaviours. This effect has been described as 'the tendency to believe that what people do reflects who they are'. This is especially likely to occur when someone has little experience of the external factors that drive addiction. The mental short cut of hearing the word 'drugs' and immediately associating this with fear leads people with drug and alcohol problems to be personally blamed and shamed.

As people learn more they are less likely to blame an individual, and more likely to seek an understanding of the complex social drivers of the harms of addiction, such as poverty, deprivation, childhood experiences, poor health, social policy and lack of social mobility and opportunity. Gaining knowledge and experience means the mental short cut is interrupted by a more thoughtful consideration. However, as Tim Berners-Lee observed, the benevolent design of social media, which offers the promise of a collective considered judgement on the world around us, so often presents simple, quick and shallow mistaken thinking that reinforces prejudice instead.

With this in mind, we set out to analyse all public UK social media posts on the subject of drugs and alcohol over a two-month period between December 2018 and January 2019. Unsurprisingly, we found more than 75,000 uses of stigmatising language, as well as evidence that stigmatising tweets/posts are highly likely to 'go viral'. The vast majority of these stigmatising social media posts were focused on drug use, and were not apparently intended to be directly malicious or abusive. There was a high percentage of people using stigmatising drug-related terms to be humorous in order to reap that coveted social media reward – getting attention.

However, discussion of alcohol problems and homelessness was much more compassionate. Here we saw the more benevolent design of social media coming into effect, with more discussions of an empathetic nature involving broader social context and social policy implications. This suggests that the more familiar issues of alcohol problems and homelessness reduce the tendency to blame the individual, and increase the likelihood of consideration of the context of the issue. We also saw these more considerate messages gaining the reward of online attention in the form of likes, shares and retweets.

So, what can we do to encourage the benevolent design of social media to reduce stigma? Our sector has a longstanding, strong tradition of sharing life stories as a means of reducing blame and shame. One strategy that has potential is to tap into this tradition of story sharing through social media.

First person stories told by people with first-hand experience convey the reality of addiction with nuance and context. Internal thought processes are explained and the reader has the opportunity to connect with the issue on a deeper level than purely observed second-hand behaviour. Through stories, the reader/viewer can get to know the storyteller and connect on an emotional level with their hopes and fears, vicariously experiencing the way the storyteller sees the world in which they live. Storytelling breaks down the shallow polarisation of 'us and them', and brings people together as a shared 'us'.

What we have seen, then, is that stories can combat stigma by activating social media's benevolent design potential to create a compassionate community of support. We encourage others to explore this potential in a manner that is creative, engaging and respectful to the storyteller.

You can read the Phoenix report Care to share – social media conversation about addiction, recovery and stigma at www.phoenix-futures.org.uk

James Armstrong is director of innovation and marketing at Phoenix Futures

Thomas reached more than 17,500 people on Facebook alone with almost 1,000 people engaging with his story

As we approach Hepatitis Awareness Day, **Ignatious Harling** shares his progress as a hep C peer educator

VITAL BONDS

I caught hepatitis C back at the start of the '80s and didn't get treatment until 2010. I wasn't always treated particularly well by the medical profession back then. It was clear they thought I'd brought it on myself and weren't going to offer treatment unless I was abstinent for a year. There was also a load of misinformation around; they used to tell me not to worry as I'd probably die with it rather than from it.

These days, it's different. Everyone gets treated whether they're abstinent or not, there's specialist support, and the testing and treatment is far quicker and more effective. But not everyone knows things have changed. And a lot of people lost trust in the system because it didn't support them when they needed it.

That's where I come in. I go to different support groups and talk to people about hepatitis C, dispelling the myths. I chat about my own experience and offer to give them the test there and then. There's something about it coming from me, someone who has been there and got through it, that makes a connection with people.

It's that connection, which I can't quite put into words, that drives me in this role. It has a wider impact on people that goes beyond a simple test in the fight to eliminate this virus. It is a psychological step to opening up, a footstep on the road of self-care, a toe back in the water to test whether the medical world will accept them now. It's the invisible benefit of doing this kind of work and it's hugely motivating.

Unfortunately, people who need testing the most are those who have a history of injecting drugs and they still expect that old-style approach. They're surprised to hear that these days they'll be treated as human beings first with a recognisable health issue. There's a lot of relief when they find out it doesn't matter what they've done or are still doing, that they're still entitled to be heard, seen and treated for this life-threatening illness.

Some have also ignored the idea they may have hepatitis C because they don't want to think about it when life is too stressful in other ways. It's known as the silent killer as there are apparently no real symptoms. I think that's particularly true when you're using drugs or alcohol. It wasn't until I became abstinent that I noticed I had chronic fatigue and some cognitive difficulties. Up until then I just thought that was caused by age or substances.

The treatment I went through almost ten years ago was using the drug interferon which is very aggressive and hammers your immune system, with a 70-75 per cent chance of clearing the virus. It's an elephant drug to shoot a butterfly. The new treatment is very targeted, much less aggressive so there's a faster recovery time, and it's 98 per cent effective. It's a complete game changer.

'My long-term hope is that we achieve the goal of eradicating hepatitis C altogether. It's achievable and... there's the chance to do so much more along the way.'

My long-term hope is that we achieve the goal of eradicating hepatitis C altogether. It's achievable and with peer educator projects like this, there's the chance to do so much more along the way. There's a good recovery community here in Bournemouth – I've bumped into lots of people I've tested now and it's created a sort of bond. Someone else took a step to help them and that's planted an important seed. You can almost see it growing, and it's beautiful to watch.

World Hepatitis Day is on 28 July. Let us know what you are doing to raise awareness of testing and treatment.

ON A ROLL...

Ignatius Harling is a peer educator at Addaction Bournemouth which has piloted work using peers to educate and support people to get tested for hepatitis C. The project has been a success and is expected to be rolled out across Addaction services around the country. The peers were Addaction volunteers trained by the Hepatitis C Trust.

Addaction's blood-borne virus lead, Helen Hampton, says, 'The test is a simple dry blood spot test, but we found that with the best will in the world people didn't come back in to have it done. With someone like Ignatius able to do it for them there and then, people who have refused to be tested before are now getting checked, which is fantastic.'

Addaction Bournemouth is now recruiting more peer educators to expand the project. **Find out more at www.addaction.org.uk**

ONLINE PURCHASING

ATangled W

The ‘darknet’ online marketplace has experienced significant turbulence lately, affecting the availability of different drugs. Be ready for the impact, says **Kevin Flemen**

A series of international policing operations has made a significant dent in darknet market places. While it’s inevitable that new models and markets will emerge, in the short term these changes will have a significant impact on the UK drug supply. Drug services should be aware of this now so that they can respond promptly to the shifts in availability.

Darknet drugs markets have been around for a few years now. The most famous early example, Silk Road, was shut down in 2013 and its successor, Silk Road 2.0, closed a year later. Predictably, more darknet drugs markets emerged to fill the void, including Agora (shut in 2015) and Alphabay.

Alphabay was shut down through an FBI operation in 2017 – but importantly, this was part of ‘Operation Bayonet’, a two-pronged attack. Many people trading on Alphabay migrated to another market, Hansa, which had already been infiltrated by Dutch Police. This allowed international law enforcement to identify both buyers and sellers, resulting both in prosecutions and wariness about the safety of other markets.

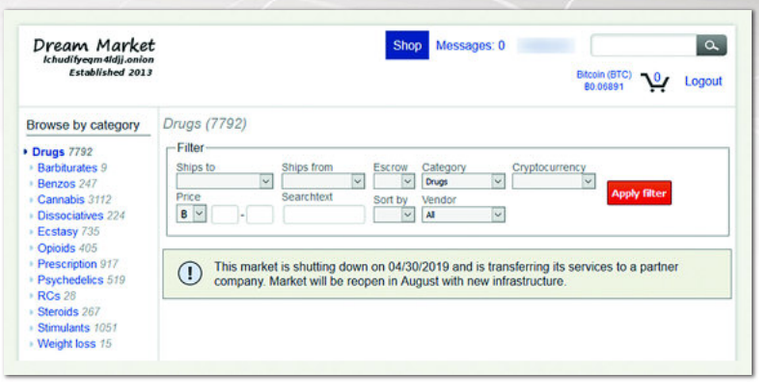
While these other darknet sites were either voluntarily closing or being shut down by enforcement, one, Dream Market, continued to function and grow. Originally established in 2013, it had risen to being the largest darknet drug market place. In March 2019 it had some 120,00 market listings, more than ten times its nearest competitor. It was easy to use, had a large number of vendors apparently located within the EU, a lot of vendors with long selling histories, and was as ‘trusted’ as any darknet marketplace can be.

Then in March 2019, Dream Market suspended trading. After logging in, customers were told that the market would close in April 2019, and a new operation with a new partner would be launched.

Dream Market had been subject to intense denial-of-service attacks, making it harder to trade on the platform. But the abrupt suspension of trading came out of the blue. There was an opportunity for people to extract any bitcoins lodged with Dream Market, dispelling myths that it was an ‘exit scam’ where the site ran off with the money. But the orderly suspension of Dream Market couldn’t disabuse people of fears that the site had been infiltrated, or that any successor site wouldn’t be another ‘sting’ like Operation Bayonet.

As before, people flocked to the next functional market, Wall Street Market. This was then probably part of an exit scam, and new subscribers lost money. Wall Street Market was then shut down.

In order to find the next reliable darknet drugs market, the easiest directory to use was DeepDotWeb which linked to the main markets, offered reviews and provided updates on their status. In May 2019 this website was seized by the FBI and the people behind it arrested for allegedly receiving kickbacks for sales generated via the drug markets to which they linked.



‘If laws of supply and demand hold true, cost may well go up, and quality may also suffer.’

So, since March this year the largest two darkweb drug markets have been shut down, and the directory site that pointed people to these sites and any future ones was also shut down. It was the drugs equivalent of Amazon and eBay being taken out within weeks of each other – then Yellow Pages being closed down too.

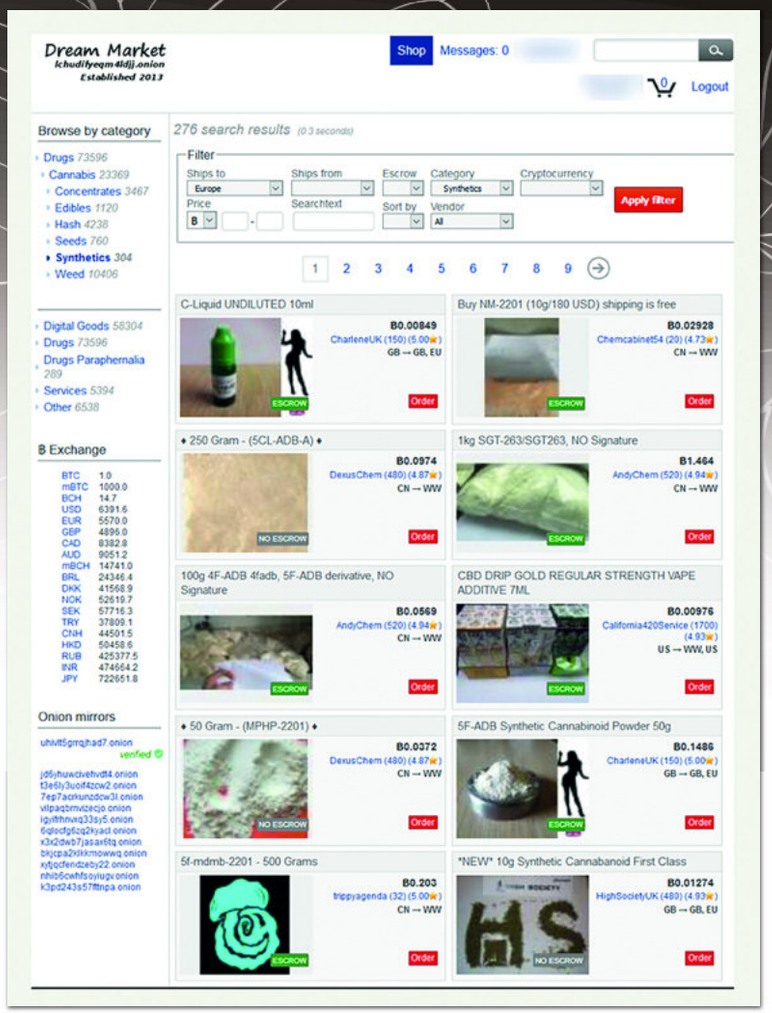
It’s almost inevitable that new markets will emerge and grow. There’s a new directory service running, and emergent markets trying to fill the gap. But it will take a while for any newer site to build up the confidence that Dream Market enjoyed with vendors and buyers. Such trust isn’t born overnight. The key issue in the meantime is, how does all this impact on the UK drugs scene?

Some drugs markets such as the UK homegrown cannabis market or the more ‘traditionally’ smuggled drugs such as heroin and cocaine will probably experience less disruption from these darknet closures. Indeed, closing down the online competition effectively ‘gifts’ a large market to the existing street suppliers – a position that the ‘county lines’ gangs are well placed to exploit. It’s a bonanza for traditional drug gangs and emergent dealer networks.

So where is disruption more likely to be experienced?

More from Kevin Flemen at www.drinkanddrugsnews.com

Veb



THE HIDDEN POPULATION BUYING PHARMACEUTICALS AND OTHER SUBSTANCES FOR MEDICAL OR QUASI-MEDICAL USE.

As UK prescribers have started to clamp down on benzo, opiate and pregabalin prescribing, a cohort of people have been sourcing these off the darknet. There are also people buying THC for medicinal reasons and people microdosing on mushrooms, LSD or ketamine. We have no idea how large this market was.

With the demise of Dream Market, anyone reliant on this market place and possibly physically addicted to the substances they were purchasing will need to access treatment. They may not be able to wean themselves off their own stash – their supply just vanished. This will be a key concern for those who have been sourcing Xanax (alprazolam) off the darknet. I suspect a degree of scarcity as stocks already in the UK dwindle.

RECREATIONAL CLUB AND PARTY DRUGS.

Dream Market had made it easier to buy a range of club drugs, from obscure psychedelics to MDMA, with a better chance of getting some product that was reviewed by other purchasers. With the summer festival season upon us, a host of recreational users will be obliged to go back to suppliers in clubs and festivals, with all the elevated risk that this entails. Granted, there was always a level of uncertainty with any pill, as the escalating potency of pills on the market shows. But even the modicum of safety provided by the darknet sites has now been removed.

SYNTHETIC CANNABINOIDS.

My suspicion is that it will be harder for the smaller city-level dealers who have been buying in SCRAs (synthetic cannabinoid receptor agonists) – for onward sale to prisons and the homeless population – to source products. Granted, some will buy directly from manufacturers in Asia. But low-level suppliers were buying from importers and redistributing to prisons and the street, and it is at this level I think availability will go down. While less 'spice' is no bad thing, the obvious drug of choice, especially for the street homeless SCRA users, is heroin. Anecdotal feedback from training says that this has already started to happen in some areas.

Any changes will take a while to trickle through to the street drugs market as existing stocks of drugs are used up. If laws of supply and demand hold true, cost may well go up, and quality may also suffer. The relative 'power' of buyers, provided by the choice the darknet markets offered, is replaced by the risks of the normal street drugs market.

It is impossible to be certain what will happen over the next six months, but we can be sure that you can't remove two huge pillars of the darknet drugs market without some impact on end users. It will certainly be an interesting few months.

Kevin Flemen runs the drugs education and training initiative, KFx – www.kfx.org.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.

'Transform advocate for optimal legal drug regulation models that minimise social and health harms. In our view, legal regulation – for all its challenges – would achieve this far more effectively than prohibition...'

WELCOME DIALOGUE

Molly Cochrane raises some challenging questions around legalisation and regulation in her letter 'Awkward Facts' (*DDN*, June, page 17). Coming up with models for the legal regulation of risky drugs is certainly difficult. My colleagues and I at Transform Drug Policy Foundation have worked for over two decades to try and meet this challenge in a series of detailed publications that outline a range of possible options.

In considering how regulation might work, Molly rightly notes the delicate balance that would need to be struck between keeping prices high, and restricting availability, to dissuade use, and keeping prices low enough, and availability high enough, to dis-incentivise a parallel illegal trade. These are challenges facing both tobacco and alcohol policy and there is no perfect answer. Neither, however, is it beyond resolution: fiscal policy is based precisely on establishing taxation thresholds that achieve precisely this balance for a range of goods.

Transform advocate for optimal legal drug regulation models that minimise social and health harms. In our view, legal regulation – for all its challenges – would achieve this far more effectively than prohibition, whose failures are evident all around us. But that is not to say the regulation of currently legal drugs, such as alcohol, is perfect. Far from it. Indeed, it is entirely consistent to call for better regulation of legal drugs (such alcohol MUP and plain packaging for cigarettes – both of which we support) as well as effective regulation of currently illegal drugs. The destination of optimal regulation is the same, even if the starting point is different.

Finally, Molly cites the case of mephedrone. The unregulated legal NPS market (before the PSA 2016) was nothing like the strictly regulated model we advocate. Furthermore, mephedrone's emergence was not just because of its legal status (although that was, no doubt, a factor) but significantly due to an MDMA shortage following the 'successful' interdiction of almost the entire global supply of a key precursor in 2008. A new illegal MDMA production method was discovered in 2010 – coincidentally when mephedrone was banned in the UK – and by 2011-12 high purity MDMA pills and powder returned to the market. Following this, MDMA's user base, many of whom were previously displaced to mephedrone, largely returned, both in the UK and elsewhere, even where mephedrone remained legal.

Problems such as those identified by Ms Cochrane are difficult, but they become less awkward when, rather than ignoring or simplifying, we look at them more closely. I and Transform welcome the kinds of challenges that Molly raises in her letter and we look forward to further dialogue to help put in place measures that afford the highest level of protection to consumers using the best regulatory tools we have available.

Steve Rolles, senior policy analyst, Transform Drug Policy Foundation

COUNSELLING CREDENTIALS

It was a disappointing surprise to read the article on FDAP (*DDN*, June, page 10), which inaccurately stated that FDAP is the only professional registration body for drug and alcohol workers. This is incorrect. There is also IC&RC UK and Europe, a body that certifies drug and alcohol counsellors in the UK and has done so for over 20 years. It is a UK branch of the worldwide IC&RC 50,000-strong credentialing body and members may apply for reciprocity throughout the world.

We can be contacted at: IC&RC UK, 33 Thurloe Place, South Kensington, London SW7 2H or at info@icrcuk.org

IC&RC UK and Europe Board members

BROADREACH HOUSE ANNOUNCES CLOSURE

As *DDN* went to press it was announced that Broadreach House in Plymouth was to close due to lack of funding. The facility had launched a crowdfunding campaign to raise £250,000 to 'enable us to continue to provide excellent and effective support to those in greatest need facing addiction', but had fallen short of the amount needed.

A statement on the Broadreach House Facebook page read that 'it is with the deepest regret that we write this post to inform you of the closure of Broadreach House, including Broadreach our male only detoxification and residential service and Longreach our female only detoxification and residential service.'

Broadreach House had 'survived many years of turbulence due to underfunding', it said, but had finally 'found ourselves in a situation where we have no other option but to close our services'.

Staff had forfeited part of their salaries 'in a concerted effort to continue trading', it continued, with the added irony that the facility was currently at full capacity, with demand for its services greater than ever.

Read a selection of the Facebook comments below:

Rose Chitseko Very sad and also angry that such a valuable service, which literally saved my daughter's life, is having to close. What an enormous waste of extremely talented, compassionate staff and wonderful people generally, needed as much now as ever.

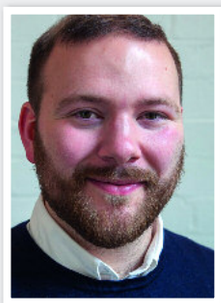
Sally Pullyblank So sad to hear this news, Broadreach helped my family when we were in such a desperate time with my mum. Unfortunately she never recovered but I will never forget the place as a young teenager and the support that was offered to her – I felt it was our only chance at the time. What happens now to all those families who are desperately seeking help for their loved ones! So very very sad.

Ivanna Bedani I'm absolutely heartbroken. This wonderful organisation saved my life, saved and healed my family's pain and helped me make the best start possible to build a happy healthy and productive life. I am forever grateful for the hard work care support and effort of everyone who worked there. xxx

Kelly Budd I honestly feel sick reading this – I can't believe that such an amazing service has fallen by the wayside this way. The staff are (and always have been) truly amazing, and the number of incredible individuals who took their steps on the path to recovery at this service should be proud of themselves and the changes they made. It is such a shame that no more clients will pass through its doors. Goodbye Broadreach!

Mandy Lea So sad to hear this, you saved my life along with many others. Will never ever forget, so sad. xx

Family Force



A new project is reaching out to families of former members of the UK Armed Forces with substance use problems, as **Rob Stebbings** explains

IT'S NO SECRET that substance use often affects the lives of former members of the UK Armed Forces. This can take many forms – from self-medication to help come to terms with a traumatic experience to difficulty transitioning from the heavy episodic drinking culture. It's a serious issue that needs addressing.

However, there is another group of people affected by this issue. The families are a hidden group whose voices are seldom heard, with little or no support available and barely any recognition or research.

Thanks to funding from Forces in Mind Trust (FiMT), Adfam and the University of York are working together to understand the experiences and needs of families of former members of the UK Armed Forces with substance use problems and what can be done to support them.

To help us achieve this we are grateful to have vital input from three family members with lived experience, and four partner organisations—the Armed Forces charity SSAFA, HMP Parc in Wales, Tom Harrison House in Liverpool, and Bristol Drugs Project.

Amanda, one of the family members supporting us shares her experience: *I became involved in this project when I read an email from Adfam and thought, 'I want to know more about this'. The topic is close to my heart after seeing my brother-in-law's deterioration from a proud warrant officer class 2 in the British Army who lived for his job, to his ultimate death from alcohol addiction after he had left the forces. This has impacted on my family's everyday life in so many ways and whilst we remember him fondly this is often tainted by the frustration of not being able to prevent his death. I am also the mother of a rifleman who at 25 is also very aware of the pitfalls of army life, but in listening to his stories of the young men he works with I see that the cycle of coping through the use of substances continues. I am hoping my involvement with the project will provide families with the support they need and believe that Adfam and the University of York can deliver this for them.*

ONLINE SURVEY

At the beginning of July we launched an online survey to hear from families first-hand. Findings from the survey and the other parts of the research will be used to develop a peer support intervention.

If you're a family member affected by these issues, please do take part in our survey and circulate information about it to your networks. All participants are in with a chance of winning one of two £50 high street vouchers.

Take part here: http://bit.ly/family-veterans-survey

To find out more about the project contact Lorna Templeton, senior research fellow, University of York – lorna.templeton@york.ac.uk; or Rob Stebbings, policy and communications officer, Adfam – r.stebbings@adfam.org.uk

THE BIGGER PICTURE

Junaid tells us how he became involved in making a film for the 2017 Recovery Street Film Festival

In 2015 I was using crack cocaine and daily endangering my own life. I was involved in car crime and mentally and physically not in a very good place.

The first time I got arrested and went to prison I stopped using but when I came out I was putting myself in more risky and dangerous situations. The last time I was arrested I was in a really dangerous car chase and ended up crashing into a lamppost. I think I almost did it subconsciously – I wanted to get caught.

In prison I had some contact with support services and found out about the damage that crack cocaine does your brain's dopamine receptors. I learnt that they needed to heal and that's when I realised that rather than keep going back, I needed to be patient and give my body time to repair. When I left prison I recognised I couldn't do it on my own and went to R3 to get support. I am so fortunate that I got help because with the road I was on someone could have got seriously hurt and I don't know where I would be today.

Creating the film *Making up 4 lost time* was a great experience and a really relevant theme because I lost a lot of time in addiction. Our aftercare group made the film, and working on a project together gave us an opportunity to socialise and combine our skills. We all found it a cathartic process and really helpful. Plus, at the end it was great fun going to the Curzon and seeing our film shown on a big screen.

We used the instructions on the Recovery Street Film Festival website to help us get going. We started with a storyboard and then went out and filmed. An American rapper gave us permission to use his song which was about a mother addicted to drugs and we used this as a basis for our story.

If you're thinking of entering, don't be shy. Whatever your idea is or how obscure, just tell your story however you want to. There is no harm in doing it – just go for it!

Two years on, I have just started volunteering with Humankind. I want to get some qualifications and then hopefully work in the field. I am also working on my film for this year!

THE CLOSING DATE FOR SUBMISSIONS TO THE 2019 RECOVERY STREET FILM FESTIVAL IS 1 AUGUST. The theme is **'My Recovery Connections'** – who were the individuals, people and communities that have supported you? How did these connections help you on your recovery journey?

More information and tips for making your film at **www.rsff.co.uk**. Watch *Making up 4 lost time* on the Recovery Street Film Festival YouTube channel.

Roger Howard pens an open letter to the new recovery champion Ed Day, in response to our interview with him last month


PROFILE

Brand New Day

Dr Edward Day has just been appointed as the government's drug recovery champion. He talks to DDN about the challenges and opportunities of the new role

'If I was going to pick one thing, it's still the stigma of drug use. There's a real job to do to break down the prejudice against people who've had a drug problem.'

DEAR ED...

All of those working in the treatment and indeed the wider peer-support field must have read your *DDN* interview last month (June, page 8) and silently wished you 'good luck'. I remember when the idea of a national recovery champion was first mooted thinking, 'what's the added value the role will bring?'

Then I saw the role detailed in September 2017 and it said, *'The champion will be responsible for driving and supporting collaboration between local authorities, public employment services, housing providers and criminal justice partners... provide national leadership, advising government on where improvements can be made to the existing system of drug treatment... encourage greater partnership working at a national level, as well as facilitating multi-agency collaboration locally...'* And I thought, phew, that's some 'ask' for a volunteer!

Don't get me wrong. We've had drug czars, drug action teams, ACMD, National Treatment Agency and assorted others including think tanks seeking to address the systemic challenges of improving policy, practice and collaboration. However, let's not ignore some of the lessons from these. The drug czar got the heave-ho when he fell out with ministers over cannabis rescheduling and how to tackle drug policy. Professor David Nutt was dismissed as chair of ACMD over his comments about the relative risks of ecstasy. Paul Hayes 'took a bullet' for the rest of the NTA team to smooth its transition into the new PHE.

Speaking 'truth to power' is like walking a tight-rope. Another lesson is that initial patronage by an enthusiastic and supportive minister can rapidly change once events and personnel change – or if they don't like your advice. So, for all of us willing you to succeed, what can we realistically expect?

MY ADVICE WOULD BE THREEFOLD:

First, ditch any idea that you can make any significant impact on local collaboration. There's some great collaborative work going on locally, but financial resources are the lubricant to keep the wheels oiled. We know the dire financial situation for local councils, mental health services, police commissioners, criminal justice and social housing. So, unless you want to be sent to The Tower for heresy, no doubt you will be advised by the civil servants to tread carefully when giving advice to the Ministerial Drug Strategy Board about the very real impact of cuts and changes like universal credit on recovery prospects.

Second, yes you can (and must) champion evidence-based practice, including peer-led services. You have ACMD and PHE efforts to back you up. When John Strang, Eric Appleby (Alcohol Concern) and myself (DrugScope) helped Mike Ashton to set up Drug and Alcohol Findings some years ago (still going strong) it was with the explicit aim of underpinning treatment, criminal justice and prevention practice through a one-stop easy access portal to the evidence base. But let's be realistic. It's a mammoth and ongoing task, akin to painting the Forth Bridge.

Which takes me to my third piece of advice and one you have already identified as a critical challenge.

The barriers to the process of sustainable recovery are considerable. So perhaps side-stepping the obvious ones of collaboration and good practice and addressing the largely unchallenged issue of stigma is a pragmatic way forward. However, you will need to tread carefully with some ministers and practitioners. When I discussed 'stigma' with them, and ways to tackle it, I recall one minister saying that 'stigma was a good thing' as it sent a message.

*****

The research and policy development the UK Drug Policy Commission undertook on the challenge of tackling stigma remains highly relevant (see: www.ukdpc.org.uk). The mountain to climb, among professionals, media and those using social media is considerable. UKDPC worked with the Society of Editors to facilitate their 2012 joint-publication, *Dealing with the stigma of drugs: a guide for journalists*. I'm sure this could be built on to take account of new media platforms.

You could do worse that cast your eye over the anti-stigma initiatives championed in the mental health field. The Time to Change campaign and subsequent off-shoots have gradually help shift public perceptions about mental ill-health. Enlisting high profile public figures' support has been invaluable. It has also engaged thousands of local people and organisations,

> 'I saw the role detailed in September 2017... And I thought, phew, that's some "ask" for a volunteer!'

building on social-contact theory and evidence to chip away at damaging perceptions and portrayals, including in the helping and caring professions. But I have to say this has been achieved over two decades and with substantial financial backing running in to tens of millions of pounds from the DoH and bodies like the former Big Lottery Fund.

A real achievement for the national (drug) recovery champion would be to persuade ministers and especially the Treasury to hand over some of the proceeds from drug-related crime and unexplained wealth orders to kick-start a new recovery anti-stigma programme. That might stimulate the National Community Lottery Fund to come on board.

Then we'd know after three years that the recovery champion has made a real impact. Good luck Ed!

Roger Howard is chair of Build on Belief and former CEO of the UK Drug Policy Commission, DrugScope and Standing Conference on Drug Abuse (SCODA)

A HOPEFUL SIGN

Concluding his theme of how to rejuvenate the sector, **Mike Trace** sees opportunity in the appointment of the recovery champion

Central government has been happy to allow the drug/alcohol treatment sector to drift and suffer cuts over the last six years. But the appointment of a government recovery champion, Dr Ed Day, gives some hope that a coherent national strategy can re-emerge. The role has no salary and no budget, but Dr Day will report directly to ministers so has the opportunity to articulate a strong case for rejuvenating the sector.

Of course ministers currently have a life span of one to three months, but we have to hope that a stable government emerges in the autumn – one with the bandwidth to think seriously about social justice and social inclusion.

By that time the recovery champion should be prepared with a concise set of data and arguments that will persuade the government to re-invest in treatment for drug and alcohol problems, and to ensure that investment is properly targeted. Here are a few ideas of what his advice should include:

REMIND THE GOVERNMENT WHY THIS SECTOR IS IMPORTANT

Substance misuse care and treatment is one of the strongest social inclusion weapons the government has in its armoury. Hundreds of thousands of the most marginalised people in our society – struggling with homelessness, worklessness and alienation, and unwilling to engage in mainstream services – decide to make contact with drug/alcohol services, presenting an opportunity to improve their physical and mental health, and start a journey towards recovery and reintegration.

When this works, the government reaps rewards in terms of reduced crime, improved public health, reduced homelessness, reduced benefit dependency, and improved family and community relationships. There is also the added bonus of undermining the power and reach of illegal drug markets.

PROVIDE THE DATA TO BACK UP ARGUMENTS

I know from experience that treasury officials need to see credible calculations of benefit before the purse strings are opened. Numbers in contact with treatment, and numbers leaving treatment and not returning, will not cut it. Neither, I am afraid, will a reduction in the risk of drug-related deaths, as long as the total number continues to increase. We have to show that our efforts deliver real outcomes for government and communities.

One of the biggest failings of the NTA, and my office before it, was not to have put in place longitudinal research that showed the sector's impact on crime, health, employment and family/accommodation. We do have a number of small-scale studies that show positive results – Dr Day needs to compile these into the best current evidence base, and make arrangements for much more meaningful evaluations in the coming years.

GIVE THEM A CLEAR DESCRIPTION OF WHAT RECOVERY LOOKS LIKE

The sector can continue debating its definition of recovery – does it require abstinence, can you be 'in recovery' and still drink or smoke problematically – but government needs a clear 'mission' to buy into. The UKDPC definition works best for me: *voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.*

But government needs to have a way of recording when someone can be considered to be 'in recovery'. We can't run client surveys to answer this question, nor can we define it in terms of the nature of their contact with services. For me, if someone is not committing crime, is in positive contact with family/significant others, and is engaged in work, study, or other positive activity, then this is a pretty good proxy measure of recovery.

BRING BACK THE POOLED BUDGET

Everybody agrees that the behaviour change that can result from drug/alcohol treatment has benefits for many government departments, but since the demise of the pooled budget, the funding burden is falling on the NHS and local authorities, while other departments such as the Home Office, DWP, and justice, are taking a back seat. (This is happening right now with the redesign of probation, where the Ministry of Justice is simultaneously saying that drug/alcohol treatment is essential to its objectives, but that local authorities must pay for it.)

The drug treatment pooled budget that was in place from 1999 to 2012 balanced this shared interest and responsibility and gave all departments an interest in contributing to shared costs and shared outcomes, at a level that no department would shoulder on its own. We need to get back to that system – with all departments contributing to programmes and pathways that deliver personal development and recovery.

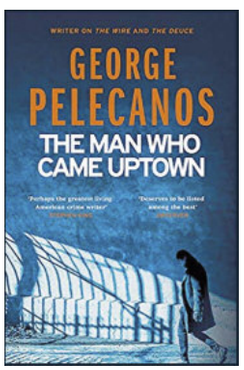
> 'A new crop of ministers needs a new vision for drug/alcohol treatment and recovery'

A new crop of ministers needs a new vision for drug/alcohol treatment and recovery – it lies in a positive investment in the potential of people who, for most of their lives, have been neglected, abused, stigmatised and punished. If we are to take social inclusion seriously, providing support to recovery and reintegration for these people is one of the most humane and cost-effective policies a government can take.

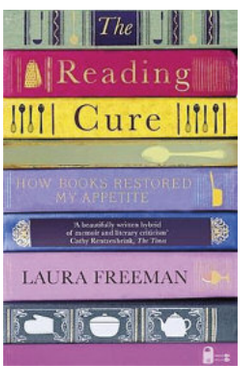
Mike Trace is CEO of Forward Trust

READING FOR RECOVERY

These two books show the power of reading in rehabilitation and recovery, says **Mark Reid**



The Man Who Came Uptown by George Pelecanos
Published by Orion Fiction
ISBN: 978-1409179733



The Reading Cure by Laura Freeman
Published by Weidenfeld & Nicolson
ISBN: 978-1474604642

GEORGE PELECANOS IS A BRILLIANT CRIME ACTION THRILLER WRITER who also attends American prison reading groups. *The Man Who Came Uptown* (got out of jail) is Michael Hudson. His early release is down to acquaintances who constrain him to commit one last crime – so serious he believes he has killed someone.

This convinces him to stay on a new path. His reading facilitator, Anna, encouraged an interest in stories of redemption and small kindnesses. It grows into a personal affection for books. Michael buys shelving to proudly 'start my own library'. When Hudson read in prison he was taken 'outside himself and his troubled mind'.

Laura Freeman needs 'a thick, sustaining book' for her peace of mind in overcoming anorexia. She is liberated and exhilarated by the gusto of certain literary characters when they tuck into a meal. Theirs is a hearty love of life and company. 'Thanks to Thomas Hardy, I drank proper milk'. The personality of the authors is a big influence. There is identification especially with Virginia Woolf: her creative highs and desperate lows.

Laura seeks a happy medium. Gluttons put her off. So do real-life faddy chia seed 'clean' eaters who compound the preoccupations 'which once existed only in my unhappy mind'. Ultimately her progress allows her to enjoy cooking and its rituals. A favourite is crispy chicken baked with fennel.

There is 'one last taboo'. Chocolate. 'It is so tangled up in my mind with ideas of sin, greed and loss of control'. She tries to read through this. Twelve whole pages are devoted to books delighting in chocolat(e). Laura last ate it in January 2003 (a third of a Mars Bar nibbled at an airport vending machine). She reveals the tortuous obsessions of the anorexic: not eating chocolate keeps in place 'the discipline, so that, if ever again I was determined to stop eating, I could do it'. Her abstinence is akin to that of the recovering alcoholic or addict. They are alike in the roles played by reward, aversion and anxiety. 'One chocolate would mean never stopping eating it'. Anyway, as Laura points out, we don't 'need' it and now she eats a range of nutritious food.

In *The Reading Cure*, Laura Freeman can read a book a day; it was always her 'indulgence'. Michael Hudson says 'books scared him'. They weren't in his old life. A friend now notices his new passion and says with suspicion 'you read books?'

From these two very different starting points, reading transforms both their lives.

> 'From these two very different starting points, reading transforms both their lives.'

MEDIA SAVVY

The news, and the skews, in the national media

> 'Michael Gove is a man who invites a number of opinions, a great deal of them unflattering...'

MICHAEL GOVE is a man who invites a number of opinions, a great deal of them unflattering, even within the Conservative party, but I am yet to meet a Tory MP who sincerely believes that it would have been better for anyone had he spent a decent chunk of the early noughties in prison. Yet the official position of his party, and that of the main opposition, is that it would.
Stephen Bush, *Observer*, 9 June

EIGHT OUT OF THE 11 TORY LEADERSHIP CANDIDATES have at various times admitted to taking illegal drugs. But all politics is hypocrisy, an edifice of pretence, insincerity and deviousness. The art lies in how you pull it off... The regulation – or non-regulation – of narcotics is quite simply the greatest social curse in modern Britain. It blights every corner of society. Gove should lead a campaign to end the indefensible 1971 Misuse of Drugs Act, and set Britain on the road to reform now being pursued by governments on both sides of the Atlantic. As a former justice secretary, and former drug user, he would be uniquely qualified for the task. At present, eight out of 11 candidates for British prime minister are criminals on the run.
Simon Jenkins, *Guardian*, 10 June

IN THIS DAY AND AGE, many people from all walks of life and in all levels of seniority, have experimented with drugs – and politicians are no different. But it shows a certain hypocrisy when they lecture the rest of us about the dangers of substance abuse. However, their experiences will not go to waste if whoever wins No10 launches an open and honest debate about drugs in our society... Only a Royal Commission examining all the facts can establish the right policy for this country. And the next PM should set one up without delay.
***Mirror* editorial, 9 June**

OPPONENTS OF LEGALISATION are fond of taking the worst drug scenarios and saying, 'So you want to legalise that, do you?' To which the answer is, 'no'. Much is made of the link between potent strains of cannabis and psychosis, for example, but the fact those strains have spread owes much to their illegality. You could say similar things about crack cocaine and heroin, or Spice, the horrible synthetic cannabinoid that now saturates our prisons. Legalisation of cannabis in some American states has, admittedly, led to a free-for-all, with little focus on regulation of any sort. Starting later, this country could do something more controlled.
Hugo Rifkind, *Times*, 3 June

Phoenix Futures describe how guests at their recent Shipley Park open day were able to witness the positive impact a beautiful natural setting can have on recovery

BACK TO NATURE

PHOENIX FUTURES' SHIPLEY PARK PROJECT hosted an open day on 27 June to showcase the project and demonstrate how it's supporting people on their recovery journeys. The day was very well attended, with more than 80 visitors accepting our invitation - with the help of glorious sunshine! Our guests had the freedom of our site at Shipley Park estate for the day, while our service users split into small groups and positioned themselves around the site offering guided tours of the various projects and discussing future plans. They were also on hand to discuss the positive impact of the project on their individual recovery journeys.

Our visitors were able to witness how those accessing the project have taken ownership of it and how they have not only experienced a positive approach and positive outcomes to their substance use but in many cases how the project has supported their mental health as well. We managed to showcase the importance of nature as an additional opportunity in treatment – who doesn't enjoy a walk outdoors in nature? The fact that natural settings are less and less accessible to those who live in cities or towns should be a cause for concern, especially with respect to overall health and wellbeing. Research continuously shows that nature has multiple benefits for our wellbeing, and our guests went away seeing first hand how this is proved through our own 'Recovery through Nature' project.

> 'We are planning more open and activity days at Shipley Park in the near future'

Guests were treated to a BBQ lunch, in which many took advantage of the green space to experience the therapeutic value of our natural setting. There were lots of positive discussions during the day, with a range of valuable networking opportunities. As such we can only grow in strength as we expand the opportunities we can offer to our service users. In turn these opportunities will increase the positive experiences of all who attend. We are planning more open and activity days at Shipley Park in the near future. This means more people will be able to visit us and experience the positive impacts on treatment and, as our networking increases, we can continue to break down the stigma around substance misuse.

Guests were treated to a BBQ lunch and had the freedom of the site while service users split into small groups and offered guided tours

Find out more at www.phoenix-futures.org.uk

More legal advice at:
www.drinkanddrugsnews.com

Accuracy and detail are key for providers, says **Jenny Wilde**

For the record

It is difficult to overstate how important good record-keeping is within health and social care settings. Good record-keeping ensures that relevant information is captured for use by carers and other professionals. That information may be needed for a variety of reasons including:

- *identifying trends for use in risk assessments*
- *monitoring changes in medical conditions*
- *providing evidence that appropriate care is being delivered*

All too often we see care records that use shorthands such as 'all care given'. A rule of thumb that carers may find useful is 'if it isn't recorded, it didn't happen'. All care, all responses to particular incidents, all discussions with professionals and other stakeholders – anything at all that is done or said about a service user – MUST be recorded.

> 'In a nutshell, when it comes to record-keeping, be thorough and seek help if you need it.'

Poor record keeping generates serious risks. First, and most importantly, service users are potentially at serious risk if important information is not captured and communicated effectively. That can lead to anything from failing to identify service users' lifestyle preferences to mistreating medical conditions in a life-threatening way.

There is, however, also a serious risk to carers and other professionals of poor record-keeping. In any investigation into the treatment of a service user – for example a safeguarding investigation or a compliance review by the Care Quality Commission – the care plan is the first document that will be looked at. Applying the rule of thumb identified above, investigators will be very slow to accept that appropriate action was taken if it was not contemporaneously recorded. Those with professional registrations, such as nurses, also risk disciplinary action if they fail to meet professional standards about record-keeping.

Writing reports requires even more care as they are bound to be scrutinised carefully. Senior management or legal advice should be sought in appropriate cases.

In a nutshell, when it comes to record-keeping be thorough and seek help if you need it. The CQC will rely heavily on records during inspections and will not hesitate to criticise a service that shows flaws in its record-keeping processes.

Jenny Wilde is director at Ridouts solicitors

WHAT, THEN, ARE THE KEYS TO GOOD RECORD-KEEPING?

The following are some useful tips:

- **ASSUME** that the person reading your notes has no previous knowledge about you or the service user in question. The more detail the better. If you find yourself too busy to make full notes, the service is understaffed. Raise the issue with your manager and if that doesn't resolve matters, consider using the whistleblowing procedure.
- **KEEP** a record of your efforts. Ensure that you don't take the fall for a service being under-resourced.
- **SEEK** and exploit training opportunities. Record-keeping is a skill which is learned and professional training can be a great help.
- **SEEK** support from managers and colleagues if necessary. This is especially important for new entrants to the care sector, those who do not speak English as a first language and anyone with dyslexia or literacy difficulties.

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We welcome your application.

For more information please contact:

Tom Hull
Call 07745 861 578
Email: tom@healthcare-people.co.uk
Website: www.frontier-group.co.uk/nx-application

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The 1ml and 2ml Solo syringes from Frontier Medical come in five colours, making it easy to identify injecting equipment and helping to reduce the risk of accidental sharing.

The ultra low dead space needles have **82%** less dead space than standard injecting equipment, helping to reduce the risk of blood-borne virus transmission caused by the sharing or reuse of injecting equipment.[1]

To learn more please visit our website or call us today.

1. Data Report on File: National Physical Laboratory. August 2018

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