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DDN

‘WHEN TWO ELEPHANTS FIGHT, THE GRASS ALWAYS SUFFERS THE MOST’

PRESIDENT JIMMY MORALES OF GUATEMALA ON HOW THE BATTLE BETWEEN DRUG CARTELS AND US LAW ENFORCEMENT IS DEVASTATING HIS NATION – FULL UNGASS ROUND-UP INSIDE

Change, grow, live is the new name of health and social care charity Crime Reduction Initiatives (CRI)

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- We empower our service users to achieve positive and lasting behavioural change. This is at the heart of everything we do.
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Our goal is to help service users regain control, change the direction of their lives, grow as a person and live life to its full potential

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EDITOR'S LETTER

'What is the point, if there's no movement on abolishing the death penalty?'

There was plenty of expectation around UNGASS – result of a 20-year wait for a global drug policy summit meeting – with a lot at stake and real hope of reform (page 6). What actually took place makes you question the value of such processes, watered down by the need for consensus. What is the point, if there's no movement on abolishing the death penalty and little progress on harm reduction?

But read the comments (page 7) and you will find cause for optimism. Our contributors talk about a change in tone, dynamic debates around health and human rights and a groundswell of opposition to the punitive approach to drugs. They point to the momentum gathering outside the UN, beyond the political aren and the drugs sector and reaching into public consciousness and debate, particularly when that debate focuses on such issues as pain control.

You'll find a lot to examine back home, in the rest of this issue. On page 10 we ask some searching questions about the workforce. Is the rise of the recovery worker linked to staffing on the cheap? Are we failing to partner the many valuable peer mentors and experts by experience with highly trained and qualified specialists to make sure our workplaces benefit from every element of support that both workers and clients need? Please let us know how things are working in your area. And if you need to know what a systematic approach to quality management looks like, turn to page 14 for James Varty's engaging journey through Kaleidoscope Project's experience.

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MUTED RESPONSE TO FIRST UNGASS SINCE 1990S

THE WORLD NEEDS GLOBAL DRUG POLICIES THAT 'PUT PEOPLE FIRST', UNODC executive director Yury Fedotov told the UN General Assembly Special Session (UNGASS) on drugs in New York, although many campaigning organisations have expressed disappointment at the event's outcomes.

The session, the first since 1998, was originally scheduled for 2019 but was brought forward following pressure from Colombia, Guatemala and Mexico – nations badly affected by the effects of the drug trade and the violence associated with drug cartels. It saw the official adoption of an 'outcome document' that has been greeted with dismay by some campaigners, who branded it 'disconnected from reality'.

UNODC remains committed to promoting approaches to prevention, treatment, rehabilitation and reintegration that are 'rooted in evidence, science, public health and human rights', Fedotov stated, adding that it would work to 'ensure access to controlled drugs to relieve pain and suffering'.

'Putting people first means balanced approaches that attend to health and human rights, and promote the safety and security of all our societies,' he said, adding that the founding purpose of the existing international drug control conventions had been the 'health and welfare of human kind'.

The event's outcome document, *Our joint commitment to effectively addressing and countering the world drug problem*, contains the reaffirmation by UN member states of the goals and objectives of these conventions, as well as a commitment to 'tackle the world drug problem and actively promote a society free of drug abuse'. The document – which was finalised at the UN Commission on Narcotic Drugs (CND) in March rather than at UNGASS itself – has been branded 'a turgid restatement of "business as usual"' and a 'profound betrayal for the many stakeholders across the world who were promised real dialogue, new thinking and change' by Transform's senior policy analyst Steve Rolles.

While campaigners have welcomed the inclusion of sections on alternatives to prison, access to essential medicines and overdose prevention, the statement could have been 'very different' if 'more progressive inputs' had been included, says Transform.

The session was originally scheduled for 2019 but was brought forward following pressure from Colombia, Guatemala and Mexico.

'The UNGASS was called for by three Latin American countries who are desperate for a critical evaluation of the failings of the global war on drugs, and an open and honest exploration of the alternatives,' said IDPC executive director Ann Fordham. 'But the outcome document does not do this. Instead it reflects the lowest common denominator consensus position that is almost entirely disconnected from reality.' IDPC was one of more than 200 civil society groups to sign a statement condemning governments for 'failing to acknowledge the devastating consequences of punitive and repressive' drug policies in the run up to the UNGASS.

www.unodc.org/ungass2016

See feature page 6

A QUIET DRINK

MUCH OF THE UK'S ALCOHOL CONSUMPTION IS 'MODERATE AND SOCIAL', according to the latest study by the University of Sheffield's alcohol research group. **In the two years to 2011 almost half of 'drinking occasions' involved 'moderate, relaxed drinking in the home', says the study – which is based on the alcohol diaries of 90,000 people – although 'pre-loading' remains a significant issue. 'Far from the stereotypes of binge Britain or a nation of pub drinkers, we find that British drinking culture mixes relaxed routine home drinking with elements of excess,' said senior research fellow John Holmes.** *Study at http://bit.ly/1niN56t*

CRYSTAL CLEAR

A NEW REPORT ON MDMA in Europe has been issued by EMCDDA. *Recent changes in Europe's MDMA/ecstasy market* looks at the 'resurgence' of the drug and wider availability of high-strength tablets and crystals. While the average MDMA content of pills in the 1990s and 2000s was between 50 and 80 mg, reported averages are now closer to 125 mg, it says. *Document at www.emcdda.europa.eu*

STREETS AHEAD

THE RECOVERY STREET FILM FESTIVAL IS LOOKING FOR SUBMISSIONS for this year's competition, the third since its launch (DDN, June 2014, page 20). **Anyone with personal or family experience of recovery from a drug or alcohol problem is invited to submit a film of up to three minutes in length, with the winning entries to be shown in venues across the country. The films can help 'show others they aren't alone in their journey and motivate them to make changes to their lives', said last year's winner Ceri Walker.** *Full details at www.recoverystreetfilmfestival.co.uk*

HEP HELP

WHO HAS UPDATED ITS GUIDELINES for the screening, care and treatment of people with chronic hepatitis C infection to include a number of new medicines approved since publication of the original document. *Revised guidance at http://bit.ly/1QrBUVr*

CANADIAN CANNABIS

'Legislation will keep marijuana out of the hands of children and profits out of the hands of criminals.' JANE PHILPOTT

CANADA WILL INTRODUCE LEGISLATION IN SPRING 2017 TO LEGALISE AND REGULATE MARIJUANA, the country's health minister Jane Philpott told the UNGASS in New York. The legislation would ensure 'we keep marijuana out of the hands of children and profits out of the hands of criminals', she stated. 'While this plan challenges the status quo in many countries, we are convinced it is the best way to protect our youth while enhancing public safety.' *www.canada.ca*

DOCTORS: E-CIGARETTES 'NO GATEWAY' TO SMOKING

E-CIGARETTES ARE MUCH SAFER THAN SMOKING, do not result in the normalisation of smoking and do not act as a gateway to smoking, says a report from the Royal College of Physicians (RCP). The controversial devices are therefore a useful harm reduction tool and 'likely to be beneficial to UK public health', it states.

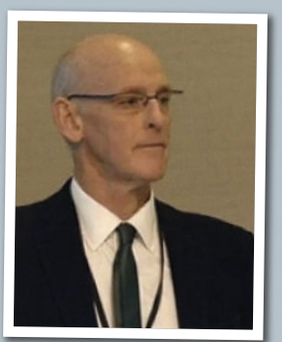
E-cigarette use is limited 'almost entirely' to people who already smoke, says the RCP, with the report finding 'no evidence' that the products have attracted significant use among non-smokers. Using them is also 'likely to lead to quit attempts that would not otherwise have happened', a proportion of which will be successful, it adds.

However the report says that concerns about the effects of long-term use 'cannot be dismissed', although the risks are likely to be less than 5 per cent of those associated with smoking tobacco. Regulation needs to be balanced and should 'not be allowed significantly to inhibit the development and use of harm reduction products by smokers', it warns. Plans by the Welsh Assembly Government to ban the use of e-cigarettes in public places were narrowly defeated earlier this year (*DDN*, April, page 5).

While the RCP acknowledges that the tobacco industry 'can be expected to try to exploit these products to market tobacco cigarettes and undermine wider tobacco control work', their use should still be widely promoted as a smoking substitute, it states.

'The growing use of electronic cigarettes as a substitute for tobacco smoking has been a topic of great controversy, with much speculation over their potential risks and benefits,' said chair of the RCP's tobacco advisory group, professor John Britton. 'This report lays to rest almost all of the concerns over these products, and concludes that, with sensible regulation, electronic cigarettes have the potential to make a major contribution towards preventing the premature death, disease and social inequalities in health that smoking currently causes in the UK.'

Nicotine without smoke: tobacco harm reduction at www.rcplondon.ac.uk



'With sensible regulation, electronic cigarettes have the potential to make a major contribution towards preventing the premature death, disease and social inequalities in health that smoking currently causes in the UK.'

PROFESSOR JOHN BRITTON

HEP GAP

DOCTORS IN THE UK, US AND AUSTRALIA ARE LESS LIKELY TO DIAGNOSE HEPATITIS C in their patients than those in other countries, according to a survey by the World Hepatitis Alliance. Fewer than 16 per cent of people in the UK were offered testing after describing hep C symptoms to their doctor, compared to 69 per cent in China. *Findings at www.worldhepatitisalliance.org*

LEGAL CHALLENGE

AROUND 60 PER CENT OF DEATHS RELATED TO 'LEGAL HIGHS' ALSO INVOLVE OTHER DRUGS OR ALCOHOL, according to analysis of figures by ONS. 'When more than one drug is mentioned it is impossible to tell which was primarily responsible for the death,' it says.

The median age for deaths is 28, compared to 38 for drug misuse deaths generally, with five out of six deaths among men. *Deaths involving legal highs in England and Wales: between 2004 and 2013 at www.ons.gov.uk*

CHEMICAL BALANCE

THE GOVERNMENT HAS ISSUED UPDATED GUIDANCE ON THE LICENSING OF PRECURSOR CHEMICALS – substances with legitimate commercial uses but which can also be used in the manufacture of illicit drugs. The regulation covers more than 20 chemicals, divided into three different categories. 'It is necessary to recognise and protect the legal trade in these substances, while at the same time discouraging their diversion for illicit purposes,' says the Home Office. *Documents at http://bit.ly/1SMHur4*

'Efforts should be better directed in trying to help those with problems overcome addictions.'

SCOTTISH POLICE FEDERATION, 2016 MANIFESTO

NEW DIRECTION

DECADES OF ARRESTING AND PROSECUTING PEOPLE WITH SUBSTANCE PROBLEMS has 'failed to tackle the root cause' of dependency, says the Scottish Police Federation's (SPF) 2016 manifesto. Although the SPF stresses that it is not advocating legalisation or decriminalisation, the document states that courts should be free to impose mandatory participation in health and education programmes, with criminal sanctions reserved for those 'preying on the vulnerable and peddling misery'. *Programme for policing 2016 – 2021 at www.spf.org.uk*

CONTROLLED ENVIRONMENTS

NICE HAS ISSUED NEW GUIDANCE ON THE SAFER USE OF CONTROLLED DRUGS LIKE METHADONE, morphine and diazepam. **Designed to help professionals navigate 'complex legislation and regulations', the guidance also includes a list of practical recommendations for storage, disposal, record keeping and prescriptions. The aim is to 'support organisations and individuals to minimise the potential harms associated with these medicines by having robust systems and processes in place', said chair of the guideline development group, Tessa Lewis.** *Guidelines at www.nice.org.uk*

STARK STATS

SMOKING IS THE 'SINGLE LARGEST FACTOR' in the difference in life expectancy between people with mental health conditions and the general population, according to an ASH report. Those with a mental health condition are twice as likely to smoke, says the document, which calls for national targets alongside better access to medications, evidence-based services and peer support. 'We know that people with a mental health condition are just as likely to want to stop smoking as other smokers,' said director of external affairs at Rethink Mental Illness, Brian Dow. 'But this can be much harder if, for example, you are using smoking as a coping mechanism.' *The stolen years – the mental health and smoking action report at www.ash.org.uk*

'Quitting is a lot harder if you are using smoking as a coping mechanism.'

BRIAN DOW

Damp Squib?

You wait nearly 20 years for an UNGASS on global drug policy and then... well, not much. See opposite for the sector's reactions to last month's event in New York, but first *DDN* hears from one of the architects of President Obama's drug policy

When UNODC executive director Yury Fedotov told the closing of the 2016 UN General Assembly special session (UNGASS) on the world drug problem that 'We must take advantage of the momentum provided by UNGASS to strengthen cooperation and advance comprehensive, balanced, integrated rights-based approaches', people could be forgiven for asking how much momentum there really was.

Reactions have ranged from cautiously optimistic to uninspired, disappointed to enraged – particularly around the content of the session's 'outcome document'. This, according to the Global Commission on Drug Policy, serves merely to sustain an 'unacceptable and outdated legal status quo'.

The document has been attacked for its failure to address capital punishment, sufficiently advocate harm reduction approaches or acknowledge the ongoing process of drug policy reform occurring across the world. It also talks about 'a society free of drug abuse', something that the International HIV/AIDS Alliance called 'a dangerous and distorting fantasy', while Transform branded it a 'shocking betrayal' of the countries that had most wanted the UNGASS to take place – Colombia, Mexico, and Guatemala.

Although the session did see Canada's health minister announce plans to introduce a legalised, regulated cannabis market, the main source of disappointment with the document was its failure to offer proposals to, in the words of the Global Commission, 'regulate drugs and put governments – rather than criminals – in control'. In other words, a significant move towards decriminalisation or legalisation.

That, according to former senior drug policy advisor at the White House and now professor of psychiatry at Stanford University, Keith Humphreys (*DDN*, June 2012, page 16), was never really on the cards. 'I think it was a fantasy to think there would be big change,' he tells *DDN*. 'I think some groups may have convinced people in fundraising, and maybe convinced themselves, that the world was going to legalise drugs in New York, and that was ludicrous. For years it was said, "Everyone wants to legalise drugs and it's just the big mean United States standing in the way".

'I think it was a fantasy to think there would be big change'

KEITH HUMPHREYS

The United States didn't stand in the way and it turns out nobody wants to do that, except for cannabis – and not all countries want to with cannabis.'

Rather than the UN, the real obstacle to legalisation is 'popular opinion in all the nations of the world,' he argues. 'In the US the majority of people want to legalise cannabis, but less than 10 per cent want to legalise heroin or cocaine – there's been no general spreading of that sentiment. If you look at polls of young people in Europe, they don't want to; if you look at polls of people in the Latin countries that are being hammered, they don't want to legalise drugs other than cannabis. So it isn't surprising, and it isn't this evil thing being imposed on the world.'

But doesn't the roster of ex-presidents and prime ministers calling for reform represent something of a groundswell of opinion? 'The Global Commission, I think, actually shows how unaccepted those views are,' he says. 'I know a number of these people are ex-leaders, but when former leaders call for something the question you should always ask is, "Why didn't they run for office on this platform?" You didn't run for this and you didn't do it when you were in office because you knew the public wouldn't like it. You can get 100 NGOs or whatever, but how many funders are there for those 100 NGOs? Are there really 100 different funders, or are there a couple of wealthy people who care about this? And that's fine, but it's not a constituency. The checkout line at Waitrose, plus George Soros, is not a constituency.'

Those advocating legalisation tend to 'live in a bubble, and talk to each other a lot', he says. So are they being naïve or disingenuous, in that case? 'I think there's a third option, which is that they don't care, and I don't mean that as an insult. Someone told me recently, "Yes, use will go up – who cares?" and I respect that. What they're saying is, it's worth it. "Yes, there'll be a lot more drug use, a lot more addiction, but that's not my problem – I'm fighting for human rights", or "I'm fighting for the free market, for business peoples' right to make a living".'

Legalisation arguments can be persuasive, he says, because it's a case of the grass is always greener. 'Doing things differently often sounds good when things aren't going well, but still it seems that most people just don't buy it, in part because we have a pretty good experience of how sales and capitalism work – not just with tobacco and alcohol, but for anything.

'If you got rid of the UN treaties and held a plebiscite in any nation on earth – including the Latin American countries – and said, "Do you want this to be a legal, corporate industry?" people would say no. What's standing in the way is democracy, and what's making cannabis legal is also democracy. If you have the popular will, then these things are not a barrier.'

ONE small STEP

It may not have delivered any major shifts, but the mood remains cautiously optimistic. *DDN* hears what some key players thought of the UNGASS

NIAMH EASTWOOD, executive director, Release

RICK LINES, executive director, Harm Reduction International

ANN FORDHAM, executive director, International Drug Policy Consortium

STEVE ROLLES, senior policy analyst, Transform

PAUL HAYES, head, Collective Voice

YASMIN BATLIWALA, chair, WDP

'TO HAVE THE DOCUMENT ADOPTED IN JUST TWO MINUTES, **prior to any serious debate, underscores a key question – what, indeed, was the purpose of the meeting other than theatre? Having said that, what followed the adoption was encouraging since a number of countries openly lamented the failures of the document, from no call to abolish the death penalty to a lack of mention for the terms 'harm reduction' and 'decriminalisation', and complete refusal to acknowledge emerging regulated markets for cannabis. This in turn raises another question – why did these countries sign up to the document only to criticise it immediately after?'**
Niamh Eastwood

'OUR EXPECTATIONS FOR UNGASS WERE ALWAYS MODEST, and we never anticipated the kind of transformational event that some were hoping for. Our main priorities were always to ensure that pre-existing commitments on harm reduction were defended and not rolled back, so that the UNGASS resolution could provide a foundation to build towards real progress at the UN high-level meeting on HIV in June. This must now move forward and tackle the global funding crisis for harm reduction, and address the fact that we have failed to meet the 2015 target of halving HIV infections among people who inject drugs by a staggering 80 per cent.'
Rick Lines

'I NEVER THOUGHT ANYTHING WOULD HAPPEN AT UNGASS. **They vote on the resolution at the beginning of the meeting and then it's all speeches, so it really is a talking shop.'**
Keith Humphreys

'THE MOOD OF CIVIL SOCIETY ORGANISATIONS has been positive overall. Of course there are frustrations with the outcome document because it doesn't acknowledge that punitive drug control has been catastrophically damaging and unfortunately reaffirms a commitment to society free of drug abuse. However, there is some progress that was hard won which we must acknowledge, around improving access to controlled medicines and the need for proportionate sentencing for drug offences.'
Ann Fordham

'THE OUTCOME DOCUMENT had some welcome language on human rights, harm reduction and access to essential medicines but was generally a huge disappointment because it was watered down and heavily caveated by the need for consensus – any really challenging content or progressive language was vetoed by the more conservative member states. This was probably most obvious with an issue like the death penalty for drug offences – clearly illegal under international law to which all member states are party to, and already subject to a General Assembly moratorium – yet the states that are still doing it vetoed any mention of it in the document. Utterly ridiculous. Consensus policy-making can seem like a nice idea but can also be profoundly undemocratic, and favour the status quo by default – achieving change in that environment can be almost impossible.'
Steve Rolles

'THE MAIN AND MOST IMPORTANT DIFFERENCE was the huge shift in the debate. Serious discussions of drug reform, decriminalisation, regulation etcetera, are all now a legitimate part of the debate among UN member states, and the tone of those discussions is so different than what was the case even five years ago at the UN. While this is not sufficient, clearly policy change will only come when these issues enter the mainstream of policy discourse, and this is clearly happening.'
Rick Lines

'THE DEBATE ON THE FLOOR in the plenary and side events was very dynamic and positive. Country after country stood up and criticised the outcome document's shortcomings, and many raised key current issues like decriminalisation and legalisation, and structural reform of the UN treaty system, which the outcome document did not engage with at all. The narrative was very much moving away from a punitive approach towards one of health and human rights, and when old-school drug warrior rhetoric emerged it seemed from another time.'
Steve Rolles

GLOBAL DRUG POLICY

'Nine countries stood up in front of the world and called for legalisation. That may not be many, but it's nine more than last time and shows how far we've come. It's not a taboo any more...'

STEVE ROLLES

'IF WE LOOK AT OTHER DIFFICULT POLICY AREAS, whether that be the refugee crisis, global warming or the war in Syria, the UN does not generally show leadership largely because of individual member states' own views. It must be remembered that the UN is the sum of its parts, not an individual entity in and of itself. Multi-lateral agencies are not the best places to sow the seeds for regional or international reform, largely because of individual member states' own views and interests generally being paramount. This was evidenced by the statements made by Russia and many of the Asian countries, who continue to push for punitive responses to drug use and supply, despite the human rights abuses that are apparent in many of these states.'
Niamh Eastwood

'THE LAST SHREDS OF THE PRETENCE of a global consensus were ripped away as countries completely disagreed with one another via their country statements, with some explicitly stating that global drug policy had failed while others – and this group is getting smaller, although still includes powerful states like Russia – talked of the need to intensify the war on drugs.'
Ann Fordham

'WE WERE VERY PLEASED by the high profile given to the death penalty debate, and the large number of member states voicing explicit opposition to the practice. Despite its weaknesses, the outcome document does contain the strongest human rights provision ever agreed in a UN drug control resolution. So that is also progress.'
Rick Lines

'PROBABLY ONE OF THE MOST DEPRESSING MOMENTS was when Indonesia said that their drug laws – which involve the use of the death penalty – were compliant with international human rights. This was moments after a colleague from an Indonesian NGO who represents those sentenced to the death penalty had eloquently outlined the horror faced by those who have been, or are waiting to be, executed by firing squad for low-level drug offences.'
Niamh Eastwood

'AFTER A WEEK OF LISTENING TO THE DEBATES in New York, it's clear that things have shifted. More and more governments are openly voicing their displeasure with the dominant punitive approach to drugs. Having the UNGASS this year has helped to build important momentum for change, bringing many new voices calling for reform, such as other UN agencies and new actors, into the reform community – from criminal justice, development, peace building, palliative care, human rights, racial justice and religious groups.'
Ann Fordham

'NINE COUNTRIES STOOD UP in front of the world and called for legalisation. That may not be many, but it's nine more than last time and shows how far we've come. It's not a taboo any more, and if the UN system doesn't show some flexibility they will continue to implement the reforms anyway and the UN drug control system will drift into irrelevance. It's a case of reform or die really.'
Steve Rolles

'IT IS REFORM NATIONALLY that will ultimately change the international regime.' *Niamh Eastwood*

'THE UK GOVERNMENT'S MESSAGE to the UN is right – robust investment and light-touch enforcement is the path forward – but those words will ring hollow if we fail to heed them at home.'
Paul Hayes, head, Collective Voice

'IT IS CLEAR THAT NEW METRICS AND INDICATORS should be developed in the sphere of drug policy, aligning global policy with the sustainable development goals, and that guidelines should be produced that reflect the socio-economic foundations of involvement in the drugs trade. In this way, the UNGASS can make moves towards effectively dealing with the challenges posed by drug usage and mend some of the damage caused by a costly and failed war on drugs.'
Yasmin Batliwala

'THIS UNGASS WAS A SUCCESS when looking outside of the UN itself as it served as a key opportunity to publicly scrutinise failed drug policies, something which the mainstream media did reasonably well, by and large.'
Niamh Eastwood

'THE COUNTRIES SEEKING CHANGE didn't get what they wanted at UNGASS but their resolve has only stiffened, along with the solidarity between reform-minded states, and with the growing reform momentum and change on the ground they will doubtless regroup and come back stronger – with an emboldened and empowered civil society supporting them all the way. Progress can happen at multiple levels – public debate, national reforms and in multilateral agencies, and is mutually supportive. So we need to keep pushing on all those fronts.'
Steve Rolles

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FROM OUR FOREIGN CORRESPONDENT

Cautious Progress

Dr Chris Ford on the importance of keeping up the momentum

'When adding the term "abuse" to a UN document was seen as a success, I knew it was going to be a long week.'

WITH SOME EXCITEMENT and a good helping of scepticism I set off to Vienna for my first Commission on Narcotic Drugs (CND), which occurs annually and is the central drug policy-making body within the United Nations system. It was the event that was going to draft proposals for the UNGASS, which we had been working towards for the past three years.

I decided to try and soak up the experience, but when adding the term 'abuse' to a UN document was seen as a success, I knew it was going to be a long week.

The main purpose of the meeting was to create an outcome document that would be 'short, substantive, concise and action-oriented'. It was an opportunity for a detailed examination of the linkages between prohibition, violence and organised crime, the corrosive impact of corruption on many countries, to explore new distribution systems and revisit the 'world drug problem'.

Proposals had also been tabled to ensure that drug control measures were in harmony with treaties safeguarding human rights and to push back against countries applying the death penalty for drug offences.

Sadly none of this happened. After the week the consensus statement simply reaffirmed the three existing drug control conventions with no admission of flaw, fault or contradiction.

I didn't get it – how could so many countries not fight for the end of the death penalty, or insist all countries provide humane evidence-based treatment for drug problems? Why did so many allow international diplomacy to miss the opportunity for real change around drug control?

But there were some rays of hope. For the first time 'access to controlled medications for medical use' was added. Many palliative care and pain organisations had been striving for this for many years and we had focused on this in our campaign leading up to the UNGASS (*DDN*, February, page 17).

The 'outcome document' signed off in Vienna was immediately adopted in New York, meaning there was no room for change – people found this deeply frustrating. The document didn't acknowledge the comprehensive failure of the current drug control regime to reduce drug supply and demand, or the damaging effects of outdated policies on violence and corruption as well as on population health, human rights and wellbeing.

UNGASS did not address the critical flaws of international drug policy, call for an end to the criminalisation and incarceration of drug users or even urge states to abolish capital punishment for drug-related offences! Had we hoped for too much? Perhaps we need to accept and celebrate the great work many governments and civil society groups have achieved and the many positive drug policy reforms already underway around the world. This is going to be the way forward – individual countries making changes.

The next international opportunity to address this will be in 2019 when the UN plan of action that calls for a 'drug-free world' will be reviewed. We must continue to fight for health and human rights to be at the centre of all future drug policy.

Dr Chris Ford is clinical director of IDHDP.
http://idhdp.com/en/resources/newsletter.aspx

MEDIA SAVVY

The news, and the skews, in the national media

THE PSYCHOACTIVE SUBSTANCES ACT should have become law today, but its implementation has been delayed while ministers work out what they have banned... The legislation is an attempt to clamp down on designer substances that, for instance, mimic the effects of cannabis; yet arrests for possession of the real drug have collapsed in the past five years because the police say they have better things to do. The number of people cautioned or charged for possessing cannabis has also fallen dramatically even though survey data suggests cannabis use remained roughly level over the same period. This policy is confusing and incoherent. The government needs to be sure its new act works properly before putting it into practice.

***Telegraph* editorial, 5 April**

JUST SAY NO. That's supposed to be our reaction to recreational drugs. The trouble is, lots of people say yes please. As a result, the world's governments have been waging a war on drugs for more than a century. Since 1961, the battle has been orchestrated via international treaties targeting all parts of the supply chain, from the producers to the smugglers, the sellers to the buyers. Yet this supposedly united front has developed some conspicuous cracks.

***New Scientist* editorial, 6 April**

HOWARD MARKS won affection because he lived a big, brash, blame-filled life, and, more importantly, was never, ever boring. His tales were strewn with innocent victims, but who cared, because he was such a stonkingly good raconteur.

Grace Dent, *Independent*, 11 April

[HOWARD MARKS] never bumped anyone off himself. But sending a few million to a Colombian drug cartel is no better than doing business with Islamic State. It may even be worse: the sadistic inventiveness of Latin America's cartel hitmen is more sophisticated than anything that goes on in the 'caliphate'.

Tom Wainwright, *Guardian*, 12 April

[HOWARD MARKS] was a fierce and instinctive defender of free speech, a rare and precious quality... What a pleasing contrast he was to the pitiful Nick Clegg, who ceaselessly calls for drug law liberalisation with the ingratiating smarminess of a newly hatched curate.

He was at it again on the BBC's *Newsnight* last week. The programme, which recently gave the ridiculous Russell Brand a free platform for his wet opinions on drugs, filmed Mr Clegg wandering around Colombia, mouthing pro-legalisation pieties.

The former deputy prime minister clearly knows almost nothing about the subject. He's never met a cliché or a fat, juicy slab of conventional wisdom that he doesn't like.

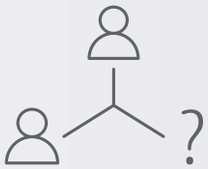
Peter Hitchens, *Mail on Sunday*, 18 April

FALSE

Is the focus on recovery undermining a highly skilled workforce? *DDN* reports

As Neil McKeganey said in 2010 (in *Controversies in Drugs Policy and Practice)*, if you need to visit a doctor you can rest assured the person you are seeing will have had a medical education. If you want to buy a house you know that the solicitor has been educated to degree level, and if you take your dog or cat to the vet you know that they will be one of the most highly trained professionals around. But if you see a drug worker you will probably be seen by someone who has not been to university, does not have a professional or postgraduate qualification, and who may have only just entered the field.

At a conference on *Workforce development: challenges, opportunities and the way forward*, speakers from different specialisms painted a picture of a sector in danger of paying the price of undervaluing essential skills, and asked, are we compromising service users' safety by 'doing it on the cheap'?



DR CARMEL CLANCY

The nurse: *'We need to find our voice'*

'There are half a million nurses working in this country, but I'm not sure where our voice is', said Dr Carmel Clancy, head of department of mental health, social work and integrative medicine at Middlesex University, who is also chair of the Association of Nurses in Substance Abuse (ANSA).

In the 1960s nurses were working in regional drug dependency units (DDUs) and the 1980s saw an increase of nurse specialists in community drug and alcohol teams. In the 1990s nurses were central to harm minimisation and there were nurse consultant roles – but the title of nurse was now becoming interchangeable with key worker and drug worker.

'Non specialists are taking over nursing roles,' she said. 'Nurses are there, but are not as visible. How do we claim a stake at the table?'

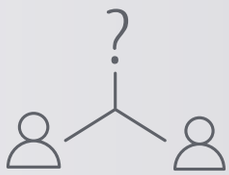
The sector had 'no idea' of the number of nurses working in addiction, with many falling into it by default, through promotion or changing location. Despite nurses seeing addiction as a specialism, they did not receive any undergraduate training on it and felt they were starting again when they came into addiction, said Clancy.

Changes were afoot however, with ANSA's proposed merger with the International Nurses Society on Addictions (IntNSA) in July, which would strengthen the nurses' voice and raise their profile in the addiction workforce.

The law change on 'non-medical prescribing' in 2012 (extending the right of a professionally qualified person to prescribe) had resulted in a growing number of nurse prescribers, added Mike Flanagan, consultant nurse and clinical lead for substance misuse services at Surrey Borders Partnership NHS Foundation Trust and chair of the National Substance Misuse Non-Medical Prescribing Forum.

The changing landscape of the last ten years had seen drug and alcohol treatment more performance monitored than any area of health and social care, he said. When commissioning moved to local authorities in 2013, the sector had been subjected to repeated cycles of retendering with diminishing budgets, all of which had contributed to making specialist addiction treatment a less attractive career option.

So what had been the impact on nursing? Medical roles were increasingly provided by non-medical prescribers – which was fine if properly supervised, said Flanagan. But with nursing posts increasingly provided by drug workers, there was 'a risk that commissioners and managers may fail to fully appreciate the impact on quality.'



DR CHRISTOPHER WHITELEY

The psychologist: *'Everyone does psychosocial interventions'*

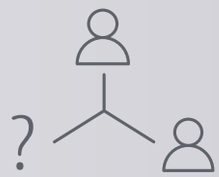
Many of the barriers and facilitators to change were psychological, but 'absolutely everyone' did psychosocial interventions now, including staff and service users, said Dr Christopher Whiteley, consultant clinical psychologist at South London and Maudsley NHS Foundation Trust.

The 'recovery juggernaut' had involved everyone in 'building recovery capital' – human, physical, cultural and social – which had helped to address issues of confidence, joining in meaningful occupations, maintaining accommodation and staying in recovery.

But there were challenges: with many of the psychosocial interventions being undertaken by people who were not psychologists, outcomes were greatly affected by the quality of the working alliance.

Organisations were prone to heavy caseloads, high turnover of clients and a lack of resources for training. To be effective there needed to be synergy between leadership, a culture of innovation, training and supervision, he said, while more could be done with families, peers and community networks.

ECONOMIES



DR KOSTAS AGATH

Addiction doctors: *'We're an endangered species'*

Addiction specialist doctors were becoming an endangered species, according to Dr Kostas Agath, medical director at Addaction. Decreased availability of addiction psychiatry training posts brought with it disappearance of skills. 'Once my generation has expired you cannot download us from the internet,' he said.

Throughout the disruptive environment of retendering we needed to make sure training plans were robust, he said. The way forward in preserving the disappearing specialism relied on a national sphere of influence, but also local sustainable solutions.

'Localism shapes the context – one size does not fit all,' he said. Future-proofing psychiatrists' roles involved effective integration with GPs, non-medical prescribers, pharmacists and psychologists.

DR SARAH GALVANI

Social workers: *'We need specialist knowledge'*

'Of 90,000 social workers in the UK we have no idea how many specialise in alcohol and drug use', said Dr Sarah Galvani, professor of adult social care at Manchester Metropolitan University's department of social care and social work, who had 'more than 30 years of identifying the lack of drug and alcohol knowledge in social workers'.

Alcohol or drug problems were identified as criminal justice or health problems, which explained the lack of engagement with social workers.

'But the vast majority say alcohol or drug education is very or extremely important to their practice,' she said. 'Most social workers can talk – but they have a problem talking about substance misuse as they don't know what to ask.'

Social workers could have three key roles – to engage with people about the topic of substance misuse; to motivate people to change and support them in doing this; and to offer follow-up support to maintain changes.

The challenges included political constraints and direct government intervention into social work education, with the devaluing of specialist practice on substance misuse. There was dissolution of specialist teams and roles, with whole services being cut and others going to the cheapest bidder.

But there were also clear opportunities, said Galvani, including the move of specialist services towards holistic and recovery-oriented approaches and embracing the wider health and wellbeing agenda, which was 'social workers' bread and butter'.

We were lucky to have a strong evidence base, new teaching partnerships and an increasing number of resources relating to social work and substance use, she said. 'We need to take the opportunities.'

A LONG AND WINDING ROAD

With a clear set of challenges ahead, the Scottish Drugs Forum is learning lessons from the past in developing its work-force programme, said George Burton

'Scotland has had a long-standing alcohol and other drug problem and has been disproportionately affected,' said Burton. Drug-related deaths were stubbornly high and had increased again, with last year's figure of 613 the highest ever recorded.

Looking back, policy responses in the 1980s had been rooted in harm reduction and methadone, until the newly elected SNP introduced a strategy of 'drug- free recovery' in 2008 (and a 'new hostility to methadone'). Drug services began changing their names to take on recovery, with drug workers becoming recovery workers.

But the quality of services depended on the quality of professionals. How much was the 'strategic objective' to recruit people in recovery about money and levels of pay?, he asked.

A two-tier workforce had meant that agreements on outcomes between the health service and voluntary drug and alcohol services were 'difficult to develop, when one half of the workforce [the NHS] was paid considerably more' and there was 'such disparity across providers'.

Alcohol and drug partnerships (ADPs) across Scotland were aligned to local authorities, and support teams included officers for different functions, such as development, policy and research, some of whom 'had no knowledge of drugs and alcohol but were responsible for big commissioning decisions'.

The Scottish Drugs Forum (SDF) provided training, which covered an introduction to the field, motivational interviewing, stigma, recovery outcomes and new drugs, as well as offering strategic support to ADPs for quality development.

A survey of service users also suggested the workforce needed local knowledge, flexibility and non-judgmental practice, and some suggested they benefited from 'lived experience'.

'Workforce development is becoming understood as more than just training, but it's taking time and it's still early days,' said Burton.

Among the SDF's current priorities were the national naloxone programme, work on quality development and service improvement, strong user involvement including a programme to train people in recovery to join the workforce, programmes on hepatitis and needle exchange, and work with the Scottish Prison Service, including dealing with NPS in prisons.

The absence of a clear pathway to the drug and alcohol field meant there was a rich mix of people with a range of experience, 'but we need to pay properly – this race to the bottom is not acceptable,' he said.

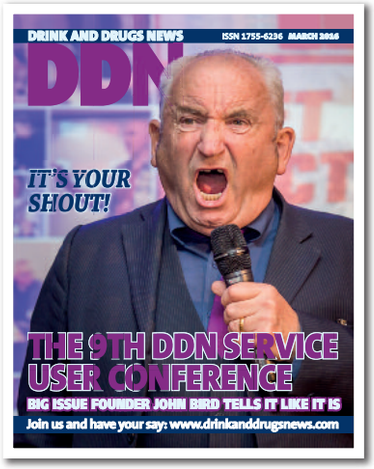
'It's important to recognise that most people can't do this type of job,' he said. 'But being in recovery does not make you a recovery worker.'

George Burton is workforce development programme manager at the Scottish Drugs Forum

LETTERS AND COMMENT

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN, CJ Wellings Ltd, 57 High Street, Ashford, Kent TN24 8SG. Letters may be edited for space or clarity.



'The "raging bull" cover was exactly what was needed to express the current state of the sector – a perfect expression of the passion and dedication that is evident, and indeed needed, to maintain our position in the current arena.'

BULL AT A GATE

The 'raging bull' cover (March issue and Colin Miller-Hoare's letter, April, page 12) was exactly what was needed to express the current state of the sector – a perfect expression of the passion and dedication that is evident, and indeed needed, to maintain our position in the current arena.

Personally I'm 'disgusted and appalled' at the politically endorsed daylight robbery that is occurring in the sector; the tender war that has resulted in so much valuable time being transferred from positive interactions with clients towards survival to provide any service at all! It's a sad race to the bottom, with the service users caught in the crossfire.

Provision has become an assault course for the most dedicated workers and they are being diverted from their primary purpose, adhering to unfit policies against most of their wishes – which strips them of pride of purpose.

Also, let's look at the comment from someone who is an expert on recovery: it was an attack on a team that has a long, successful history in representing the most complex of issues in the sector, relentlessly keeping a balance that is an accomplishment all in its own right. It was judgmental, and based on a picture that is open to perception. Colin, there is no evidence to support the reasoning that has brought you to the end result of having an opinion that is neither founded in truth, nor relevant to the providers of this wonderful magazine or John Bird himself.

I am actually shocked that this kind of retort could come from an individual who obviously doesn't understand that recovery has a basic principle not to have an opinion on outside issues. You have shown contempt prior to investigation and it has not served you well. John was raised in an orphanage, spent much of his youth homeless and in and out of prison, where he got minimal education but expanded on that on release to set up a little printer shop.

In 1995 he launched the *Big Issue*, which a number of street homeless rely on for finances to secure food and a bed for the night. He decided to forego running for mayor of London to launch a campaign that focused on social justice to promote inclusion of the homeless and other vulnerable individuals and help build a bridge to normal living, enhancing their recovery on many levels.

Had this been a 'raging bull' portrayed on the cover, my view is that it would have been more than justified and aimed at the real perpetrators who pose a threat to recovery, and I'm as sure everyone in the room would have been on the same page. It was a passionate, dedicated, well-placed call to arms that incited an equally passionate, dedicated and well-placed response in unity.

So I see a deserving portrait of a very productive conference, aimed at inclusion and challenging society's views to forge a sustainable pathway through the quagmire of stigma and discrimination, and, share every emotion evident on John's face, as did everyone there. I feel that the educational need does not lie at this end.

PS: I am honoured to have made your step one and look forward to your amends – failing which I feel you need to revise your programme, as you have not fully grasped step one. Much respect, Colin.

Kevin Jaffray, Futuremoves peer advocacy and training

ALL THE RAGE

I disagree with the negative comments about the cover of your magazine featuring John Bird. I think it represents his own struggle to survive against the odds and to provide a service for homeless people.

His speech was described as rousing, and his essential message seemed positive – everyone has skills and their life experiences can be used in a constructive way.

Mark Reid, the peer worker present, stated in his article: 'he showed how he can apply his philosophy to all people in recovery' (*DDN*, March, page 11).

In my experience, service users have to be passionate and determined to help set up services. When we had our 20th anniversary at FIRM (Fun in Recovery Management) he was one of the speakers we wanted to have as an example of someone who could use his negative life experiences to help promote a dignified service for homeless people.

John Gordon-Smith, Chair, FIRM Committee

FURTHER DISGUST

I'd just like to profess myself disgusted and appalled by the fact that Colin Miller-Hoare was disgusted and appalled by the sight of John Bird shouting on the cover of your March issue.

His absurd statement that 'there is no room for aggression in recovery' not only infantilises people but makes the ludicrous assumption that anyone who's experienced homelessness and addiction could possibly be traumatised by a picture of a shouty man.

His views are depressingly symptomatic of the current censorious drift towards the ideological policing of debate, with its attendant 'trigger warnings' and 'safe spaces' and other such puritanical, adolescent nonsense. He thinks you should 'educate your editorial staff'. I think he should grow up.

Molly Cochrane, by email

Capturing quality

What does quality look like and how do we measure it? **James Varty** shares Kaleidoscope Project's easy-to-follow system

ISO9001 is an internationally recognised, universal quality assurance standard most often associated with the manufacturing industries. So how can a system designed to ensure the quality of car parts help us in the substance misuse sector?

ISO 9001 requires an organisation to identify, define, document, implement, measure, and continually improve the effectiveness of its processes. It offers a disciplined and systematic approach that can be applied to any sector, and is being increasingly adopted in health care systems. Here at Kaleidoscope, we have considered introducing a formal ISO9001 quality management system for a number of years.

With the support of regional commissioners and the Welsh Government, we finally took the plunge with our Powys adult services in Mid Wales. Having a certified quality management system is an expectation that is increasingly being specified in tenders. More importantly, we wanted to establish a system that would help us to optimise the quality of the services that we deliver.

Powys is a large rural chunk of Wales, taking up a quarter of the country, but with a sparse population of just over 133,000 people. With a staff team operating from four primary sites and additional satellite venues, introducing a system to assist us monitor, maintain and improve service delivery and demonstrate quality was attractive to both us and our commissioners.

We of course had apprehensions. We recognise the passion and skills of our employees and trust them to work with our clients in a person-centred way in order to achieve positive, client-defined outcomes. However, we also want them to follow treatment manuals, specific interventions protocols and defined service procedures, so that we deliver a service that is tangible and consistent.

We'd already decided that ISO9001 was the most robust, recognised and trusted quality standard, so in May 2015 we engaged the services of a quality management consultancy to guide us through building our system.

The first big questions for us were 'what does quality look like?' and 'how do we know when we are doing things really well?' Given that every client has unique needs and goals, how do we uniformly measure to see that what we have delivered constituted 'quality'?

As a precursor to the ISO9001 project, we had mapped out what we delivered within our services, and defined it in operating manuals. Every key part of the treatment journey featured in the manual, and served to clarify procedures and expectations for staff.

This work actually gave us the basis of our quality management system. We took our Powys operating manual and chopped it up into a range of procedures. We concluded that quality could be defined by regularly auditing these procedures to ensure they were being followed correctly against quantitative and qualitative measures. This in turn should result in service users reporting satisfaction with the service and achieving positive outcomes.

Quality team: left to right, James Varty; Tam Mosey, Newtown team leader; Claire Price, engagement and team support worker/QMS administrator; Barry Eveleigh, Powys service manager.

After mapping out the main parts of the treatment journey as low-level process maps, we held a 'procedure speed-dating' style event in which each member of staff had a procedure, and five minutes to explain it to a colleague before moving to the next. Four hours and 28 procedures later, our long-suffering team had effectively undertaken a consultation to check through the procedures, refine them and start to understand them. Training sessions and team meetings further helped to embed the procedures into the working life of our teams.

'We held a 'procedure speed-dating' style event in which each member of staff had a procedure, and five minutes to explain it to a colleague before moving to the next. Four hours later, our long-suffering team had effectively undertaken a consultation.'

So what does our ISO9001 quality management system actually look like? To borrow a software engineering term, I would describe it as having a front end and a back end.

At the front end, we have flow chart procedures that outline the core aspects of what we deliver, such as what an initial client meeting should include and how a care planning session should be approached, right through to how a client should be discharged. These are kept electronically in a folder structure that includes all of the approved documents that are used as part of the treatment system; letter templates and written client information.

At the back end, we have documents and procedures that are less important for staff to understand. These define how the system works, including a quality policy, quality manual, controlled records log and other system-based procedures which describe how quality assurance and continual improvement is demonstrated. Straddling the two is an audit schedule, which defines which parts of the system are audited when. Typically, audits run monthly. There are some core procedures that are audited each month, such as those looking at referral, assessment and care planning. Others are run quarterly, six monthly or annually.

All of the key aspects of what we deliver as a service are defined by the system, and this in turn gives us control, consistency and a way of defining and measuring quality.

This may sound like an incredibly restrictive and formal approach to delivering a service, but in my view we can still embrace innovation and creativity in our work, because the system is ever evolving in response to service user and staff feedback, and the results of our audits.

Last November we had our second stage external compliance audit and successfully achieved ISO9001 compliance. We are still very much at the start of our quality management system adventure but continuous improvement is of course a journey and not a destination. We continue to develop and refine our system, and we still have some particular areas concerning staff training and demonstrating competence that we want to improve. However we feel that we've made a great start and I'm really proud of the benchmark that has been set by our Powys team.

We plan to use these early experiences to embed quality management system principles within our other services. I'll leave the final words to one of our Powys team members, Ben Chaffey, who says: 'The QMS helps us to work consistently with procedures, assessment and therapeutic tools. It has taken some time to get used to, but we can see the benefit.'

James Varty is head of development and quality improvement at Kaleidoscope Project, www.kaleidoscopeproject.org.uk

More about support to work:
www.drinkanddrugsnews.com

BARRIERS TO WORK

Last July the government asked Dame Carol Black to conduct an independent review into the challenges of getting and staying in work for people with drug and alcohol problems, or who are obese. With her report imminent, she gave a preview to the Drugs, Alcohol and Justice Parliamentary Group. DDN reports

'I've put drugs and alcohol in part one of the report and obesity in part two, as the challenges are quite different,' Dame Carol Black told the parliamentary group. 'We looked internationally, talked to as many stakeholders as possible and visited prisons and treatment centres.'

The first job was to get a handle on numbers, as we often didn't hear about people having problems until they were in the benefit system with another problem, such as mental health issues or anxiety, she explained.

'People worry that a specific problem might disadvantage them, so they may have something else as the primary diagnosis from their GP, such as mild depression,' she said. Many people with addiction might have other problems such as diabetes, which needed attention before they could work.

So the first problem was identification and sharing data, and the review would contain recommendations on improving this.

One of the motives for the review was to find out if there was a viable case for a mandatory route to treatment, carrying a penalty of reduced benefits. This was rejected by Black, as 'there is no evidence that being in treatment gets you anywhere nearer to the labour market'. We needed to have conversations about barriers to work, so that work became a part of treatment, she said.

The report would also identify lack of activity as terrifying for those in recovery who had been permanently busy finding their next fix of drugs. Environment was another problem, said Black: 'After treatment they would go back to friends and the environment they're trying to get away from. They need to be housed away from addicts, but taking them away from former friends and family is very difficult.'

Many wanted 'a home, partner, work and, if possible children, – but they know how difficult that is'.

The report would make recommendations about getting work into the treatment environment – and also about employers, who were 'the last part of the jigsaw'.

'Employers told us that the government needs to de-risk it for them,' she said. 'They wanted a support person on the end of the phone, so we've made recommendations on how the government might work with employers... unless we can get employers on board, it won't matter how good treatment is.'

'Employers told us that the government needs to de-risk it for them... They wanted a support person on the end of the phone.'

DAME CAROL BLACK

REACTIONS FROM THE GROUP...

'HELP PEOPLE TEST THE WATER'

'Taking a holistic view of people's lives is important. People aren't necessarily going to be ready for employment if they have health or housing issues. Practical things that can be done are helping people to get to and from interviews and meetings and help with building life skills. It's hard to provide time to do this in the treatment sector.

'We'd also like to see support pre and post employment, so there's a much more joined-up connection. We're keen on any support that could be made with local employers to move people through the system and help them test the water.'

Karen Tyrell, Addaction

'WE WILL SEIZE THE OPPORTUNITY'

'The treatment system will commit to you and DWP to do our best. The focus has been on crime, harm reduction, then recovery. Then there was the crash, and the agenda moved on. We will try to seize this opportunity to make this work.'

Paul Hayes, Collective Voice

'WILL INFORMATION SHARING BE SAFE?'

'One of the things that was concerning me was the information sharing. How would you educate people that they wouldn't be at a disadvantage, and that if they did disclose, it would go in their favour?'

Kirstie Douse, Release

***Dame Carol Black replied**: 'We can't go on as we are – in a safe and secure way we need to get that data and know what people's health problems are. If we continue with a mismatch of data we're not going anywhere. People think it might affect their benefits, but there has to be a safe way of doing this.'*

'THE SYSTEM IS SET UP TO BLAME PEOPLE'

'Stigma is one of the biggest barriers to employment. People who are stigmatised start to believe the message themselves. The whole system is set up to blame people for not being in work. Two thirds of employers would be unwilling to help them.

'It can be a slow journey, with personality or behavioural disorders and a wide range of physical and mental health illnesses. We did a survey and the barriers to getting back to work included lack of confidence, lack of computer skills and poor health. Age was also a factor for many.

'We need specialist help and in-reach, and unless you get these right, nothing's going to happen.'

John Jolly, Blenheim

THE INSPECTOR CALLS

David Finney gives the latest essential chapter on preparing for Care Quality Commission inspection

Do you know what's is happening with CQC inspections? You may have had a CQC inspection already, or you may be waiting for the next email or visit. Well, from now on all inspections will be announced approximately 20 weeks in advance, giving you an opportunity to send all the information to CQC in a 'Provider Information Return' in advance of the visit.

1. DETOX SERVICES:

The emphasis during inspection will be on the clinical and prescribing aspects of the service and CQC's expectations are that there will be:

- *Medical oversight by:*
- *A consultant psychiatrist with specific addiction treatment knowledge or*
- *A GP with at least RCGP part 1 in the treatment of alcohol and drug misuse.*
- *Nursing staff with the right training.*
- *Adherence to NICE guidelines on alcohol and drug misuse.*
- *Clinical assessment tools.*
- *Thorough physical health assessments on all people joining the service.*
- *A multi-disciplinary team (MDT) which coordinates treatment.*
- *A clinical governance framework which includes audits, a track record on safety and quality assurance.*

2. MENTAL CAPACITY ACT AND THE DEPRIVATION OF LIBERTIES SAFEGUARDS (DOLS)

CQC have a statutory duty to monitor the implementation of this Act. Obvious examples of where this Act applies are when a person is intoxicated and so has no capacity to make a sensible decision, or when they have alcohol-related brain injury which limits their cognitive functioning. So:

- *Staff need to be trained and be able to explain the principles behind the legislation.*
- *Staff need to be able to explain that any restrictions in the treatment programme are not infringements of people's liberty, but agreements which people make to ensure effective treatment.*

3. ENFORCEMENT

It is important to highlight the fact that CQC have become much more robust in their enforcement procedures. This means that where services are found to be non-compliant:

- *CQC may initially seek the voluntary agreement of the provider to cease admitting people to the service until certain measures are in place.*
- *In some cases CQC may quickly issue statutory warning notices if they believe that concerns about practice are serious.*

4. OTHER CRUCIAL AREAS

- *Risk assessments and risk management plans need to be clearly outlined. Recently CQC have specifically been asking about risks associated with early discharge, suicide or self-harm and destabilisation following detoxification.*
- *Documentation must be thorough. There must be an audit trail of decision making and care planning. Also CQC may ask for a whole range of policies and procedures be sent to them.*

5. WHAT DO YOU NEED TO DO?

Ensure all staff are inducted into the meaning of the CQC regulations and the five key questions.

Undertake a thorough audit of the operation of your services before your inspection. If you are not sure what to do, then seek advice from an external advisor/trainer who can explain exactly how to achieve compliance.

David Finney will be running a one-day workshop on 30 June in central London focusing on mental capacity and detoxification in CQC inspections. Details at https://drinkanddrugsnews.com/cqc-training/

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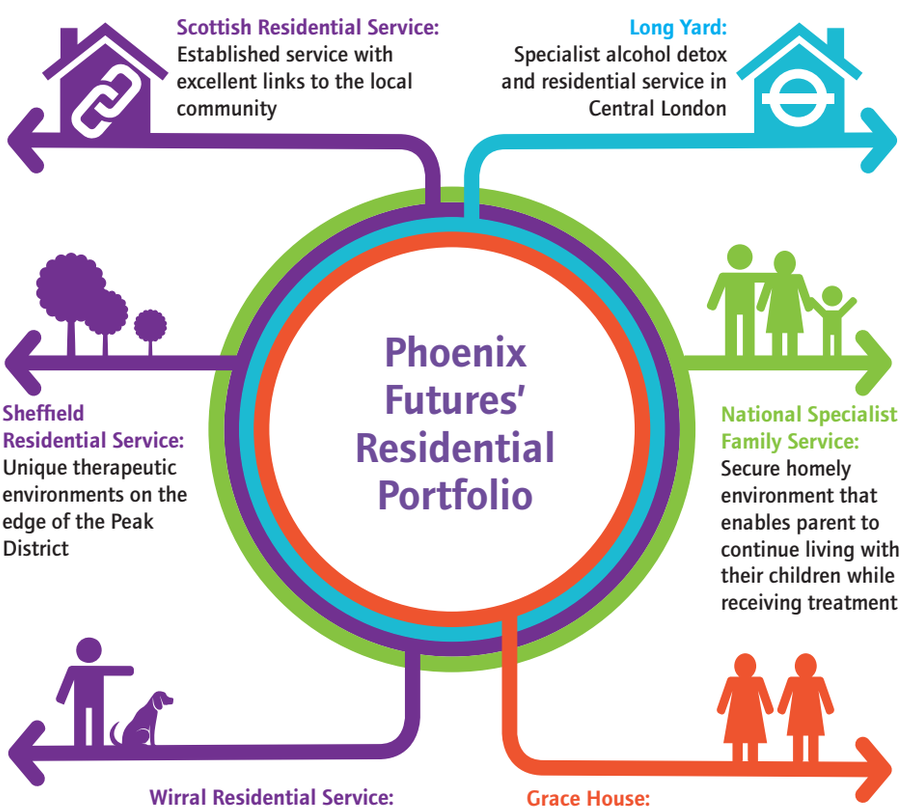

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As a growing specialist provider of Prison Mental Health and Substance Misuse Services Inclusion is pleased to announce from the 1st April 2016 we will be providing services across West Yorkshire, South Central and West Midlands.

This is an exciting opportunity to join our team in delivering first class mental health and drug and alcohol interventions within the above prisons.

As the Senior Manager across Inclusions Oxfordshire Prison Services you will be responsible for our the strategic and operational management of our Prison Psychosocial Substance Misuse and Secondary Mental Health Services across HMP Huntercombe, HMP Bullingdon and inreach provision to IRC Campsfield House.

We are looking for an experienced and dynamic leader with experience of Criminal Justice and Health service management. Ideally you would have experience or understanding of both Mental Health and substance misuse and a track record of successful delivery against targets. You will need to be self-starter who is able to motivate and lead others and who is able to develop good working relationships with colleagues, commissioners, partners and service users.

Inclusion aims to combine public service values, which drive the most progressive elements within the NHS, with the commitment to tacking social exclusion shown by the best of the voluntary sector. We deliver a range of both criminal justice and community based Forensic Mental Health, IAPT and Substance Misuse Services.

Applications: https://www.jobs.nhs.uk/
For more information about Inclusion: www.inclusion.org

NHS Inclusion: South Staffordshire & Shropshire NHS Foundation Trust. Stonefield House, St George's Hospital, Corporation Street, Stafford ST16 3AG T: 01785 221662 W: www.inclusionuk.org

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swanswell

Swanswell are recruiting...

We're expanding our services and have a number of exciting roles to fill:

- **Substance Misuse Workers** – Worcestershire, £22,665 pa
  Co-ordinating the treatment of service users, to help them to deal with their substance misuse.
- **Arrest Intervention and Referral Service Worker** – Avon and Somerset, £19,000 pa
  Helping people in custody access and engage with relevant alcohol and drug services.
- **AIRS Recovery Worker** – Bridgewater, £16,214 pa
  Offering practical support to service users, so that they can change their lives and be happy.

Swanswell is a national recovery charity that believes in a society free from problem alcohol and drug use; that everyone deserves the chance to change and be happy. Our friendly, professional team are committed to helping people turn their lives around. We know people are our greatest asset, so we recruit those whose desire to change lives for the better can help us make a real and lasting difference. In return we offer flexible working hours, a salary sacrifice pension, and a fantastic flexible benefits scheme.

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OUTSIDE EDGE THEATRE

Outside Edge Theatre Company is looking for an

Associate Theatre Facilitator

The Outside Edge Theatre Company works from the perspective of creating theatre and drama with people affected by substance misuse. Through our programmes of work we use theatre and performing arts to give people affected by drug and alcohol addiction a voice—enabling them to reach and recognise their potential, find an identity and build skills and confidence in order to support recovery. Additionally, the company provides interactive drug and alcohol treatment touring productions, training for professionals, stand-alone programmes, and professional theatre productions of new work for the general public.

This is a freelance position responsible for leading Edge Two, a new intermediate theatre workshop for participants who are in recovery or have been affected by substance misuse. This role will also involve supporting the Artistic Director and Creative Producer with the advocating and promoting of Outside Edge Theatre Company.

Applicants must be an experienced theatre practitioner with a proven track record of delivering drama and performing arts workshops, specifically delivering forum theatre, devised and ensemble and physical theatre. Experienced and proven track record of experience of facilitating with vulnerable groups. Experience or understanding of addiction and the recovery field. A Degree, MA or long term relevant experience would be essential to the role.

For more details please contact us by email to recruitment@edgetc.org or apply with CV and a letter of interest. Deadline 3 June 2016

www.edgetc.org