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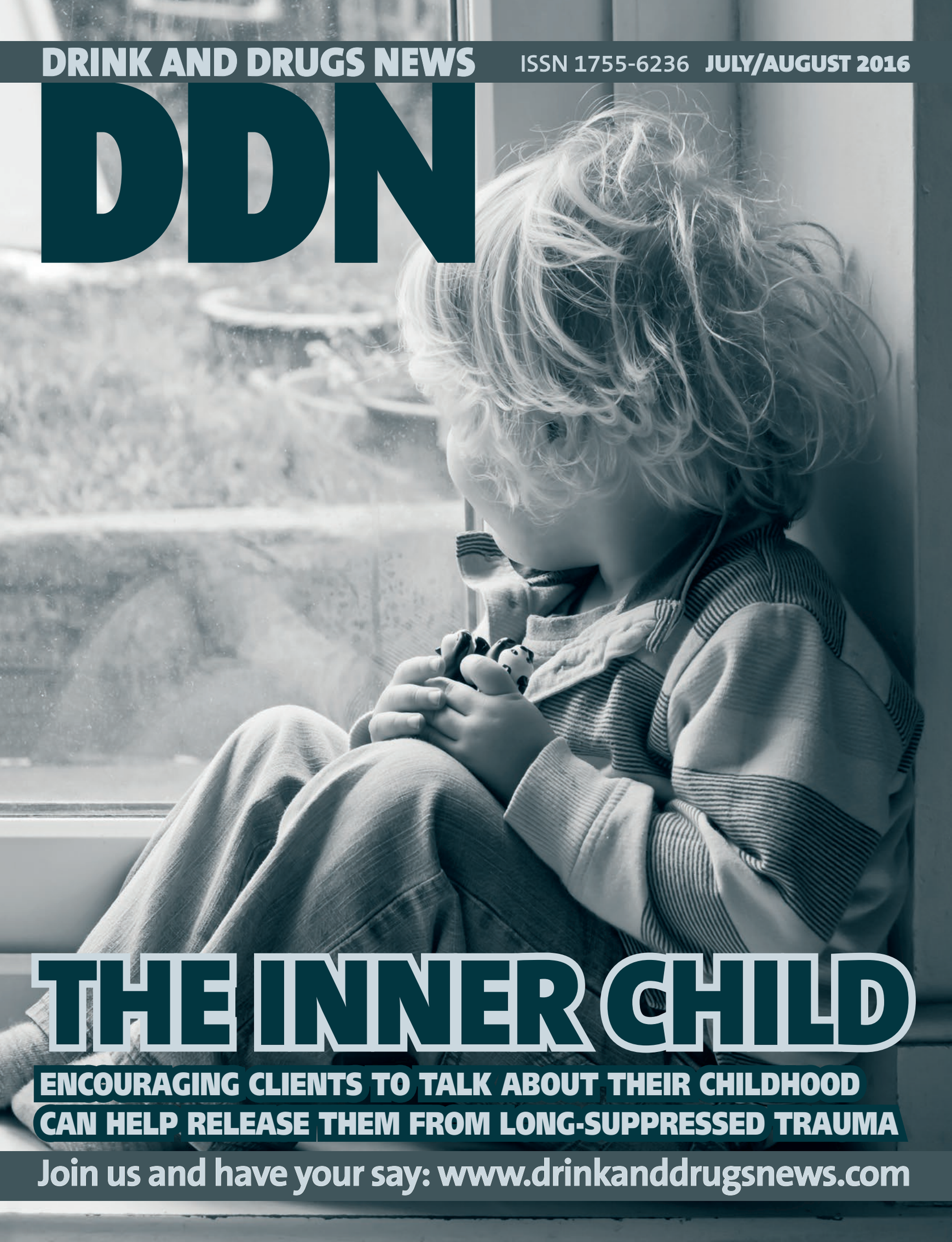

THE INNER CHILD

ENCOURAGING CLIENTS TO TALK ABOUT THEIR CHILDHOOD CAN HELP RELEASE THEM FROM LONG-SUPPRESSED TRAUMA

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ON THE COVER

Encouraging clients to talk about their childhoods

EDITOR'S LETTER

'There's a clear case for acknowledging the scale of the problem and reaching out'

Our cover story addresses the most difficult, hidden and painful issue of abuse in childhood and its links with substance use (page 8). As psychotherapist Elaine Rose explains, a startlingly high proportion of people with problematic drug or alcohol use or other addictions have suffered such trauma and when you link that with those using mental health services, there is a clear case for acknowledging the scale of the problem and doing much more to reach out to those affected. Carrying the burden of such experiences should never be the hidden problem that stands in the way of treatment and help, when our professional skills could be tuned in and shared to start the healing process.

Looking out for those affected by painkiller addiction is another area where we need to liaise with other healthcare colleagues. Cathryn Kemp's harrowing story (page 13) demonstrates how fast and far the problem can escalate – in her case nearly killing her by the time her doctor decided to stop prescribing. Who could have helped her – the doctor, pharmacist, drug services, specialist pain teams? Talking to those with an interest in acting to stop this growing epidemic, there is sparse reliable data to put in front of commissioners and Public Health England – just anecdotal evidence, patchy local data and a few specialist research papers. As our interviewees suggest, surely it's time to get around the table.

This is our 'bumper issue' for the summer, but we'll be taking advertising online as usual and we'll be active on Twitter and Facebook. Have a good summer – and stay in touch!

Claire Brown, editor

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PUBLIC HEALTH BODIES CALL FOR DECRIMINALISATION OF DRUGS

A REPORT FROM THE UK'S TWO MAJOR PUBLIC HEALTH ORGANISATIONS has called for the personal possession of all illegal drugs to be decriminalised.

Published by the Royal Society for Public Health (RSPH) with the support of the Faculty of Public Health (FPH), *Taking a new line on drugs* also wants to see lead responsibility for the nation's drug strategy transferred from the Home Office to the Department of Health, aligning it more closely with strategies for alcohol and tobacco.

The report – which generated approving editorials in several newspapers and was the front page story in the *Times* – advocates a Portuguese-style model where possession remains prohibited but users are referred to treatment programmes rather than prosecuted, moving from a 'predominantly criminal justice approach towards one based on public health and harm reduction', it says. The organisations are also calling for universal provision of 'evidence-based' drugs education through statutory PHSE education in schools, as well as the use of evidence-based 'drug harm profiles' to inform enforcement priorities and public health messages.

The current legal framework around drugs is confusing and sends 'misleading signals' to the public, says the document, nor does it correlate with the evidence when it comes to assessment of relative harms – a situation is that is 'likely to get worse' with the introduction of the Psychoactive Substances Act (*DDN*, June, page 4). Criminalisation also fails to address the underlying issues associated with drug use, it adds, while the harms associated with it fall disproportionately on disadvantaged groups and so exacerbate existing health inequalities.

'For too long, UK and global drugs strategies have pursued reductions in drug use as an end in itself, failing to recognise that harsh criminal sanctions have pushed vulnerable people in need of treatment to the margins of society, driving up harm to health and wellbeing even as overall use falls,' said RSPH chief executive Shirley Cramer. 'The time has come for a new approach, where we recognise that drug use is a health issue, not a criminal justice issue, and that those who misuse drugs are in need of treatment and support – not criminals in need of punishment.'

Report at www.rsph.org.uk.

See news focus, page 6

Why people use drugs

2 IN 5 TO RELIEVE PAIN

2 IN 5 TO BE SOCIABLE

ALMOST **1 IN 5** TO RELIEVE DEPRESSION AND/OR ANXIETY

1 IN 3 TO FEEL MORE RELAXED

And why they don't

ALCOHOL OR TOBACCO

1 IN 4 SAY IT'S TOO RISKY OR HARMFUL

1 IN 6 DON'T LIKE OR DESIRE THE EFFECTS

1 IN 10 DON'T WANT TO RISK ADDICTION

ILLEGAL DRUGS

1 IN 10 DON'T LIKE OR DESIRE THE EFFECTS

1 IN 4 SAY IT'S TOO RISKY OR HARMFUL

1 IN 10 DON'T WANT TO RISK ADDICTION

Source: RSPH public opinion survey of 2,090 UK adults carried out on behalf of RSPH by Populus, 12-14 February 2016

INTERVENTIONS UP

THERE WERE NEARLY 100,000 ALCOHOL BRIEF INTERVENTIONS carried out in Scotland in 2015-16, according to official figures – 59 per cent more than the government expected in its local delivery plan estimate. The last three years have also seen a three-fold increase in the number of interventions conducted in wider, non-priority, settings such as criminal justice and social work.

Statistics at www.isdscotland.org

LIFE LESSONS

DRUG AND ALCOHOL DEPENDENCY is one of the themes of the government's new 'life chances fund', an £80m initiative to tackle entrenched social issues. The project will support social impact bonds (SIB) to 'help transform people's lives', says the Cabinet Office, and is launching alongside a new centre of academic excellence for commissioning public services, the Government Outcomes (GO Lab), in partnership with Oxford university. 'This is about central and local government, academia and the voluntary sector all coming together to work at tackling some of the most entrenched social challenges we face,' said civil society minister Rob Wilson.

Expressions of interest invited at www.gov.uk/government/publications/life-chances- fund until 30 September.

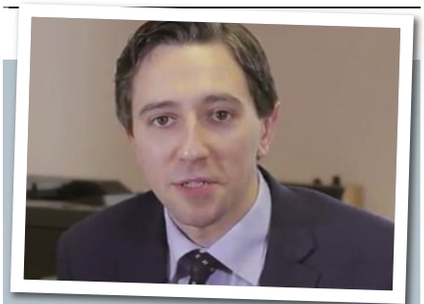
TAKEAWAY TROUBLE

SCOTTISH DRINKERS could consume their entire recommended weekly unit limit for just over £2.50, according to Alcohol Focus Scotland. A survey of supermarkets and convenience stores in Glasgow and Edinburgh found wine on sale at 32p per unit, lager at 26p per unit, and three-litre bottles of 7.5 per cent cider at just 18p per unit. Chief executive Alison Douglas said, '£2.52 is the price of a takeaway coffee yet this can buy the weekly recommended alcohol limit of 14 units. The more affordable alcohol is, the more we drink and this means more alcohol-related hospital admissions, crime and deaths.'

'NPS users are three times more likely to seek emergency medical treatment...'

DARK DAYS

MORE PEOPLE ARE BUYING THEIR DRUGS ON THE 'DARK NET', according to the latest *Global drug survey,* with MDMA, cannabis and NPS the substances most frequently purchased. Nearly one in ten respondents reported having bought drugs this way, with 5 per cent saying they'd never taken drugs before buying them from dark net sources. The UK had the highest overall last-year use of NPS, while NPS users were three times more likely to seek emergency medical treatment than users of traditional drugs. *Full results at www.globaldrugsurvey.com*



CONSUMING SCHEMES

THE IRISH GOVERNMENT intends to proceed with plans to open the country's first supervised injection facility this year (*DDN*, October 2015, page 4), health minister Simon Harris told the *Irish Independent* newspaper, with the drafting of the necessary legislation now 'at an advanced stage'. The site will be in Dublin, a city that has seen increasing problems with street injecting, while the country has also experienced a spike in blood-borne virus transmission. Meanwhile, the Glasgow City Alcohol and Drug Partnership (ADP) has established a working group to look at opening a facility in that city, along with plans for heroin-assisted treatment.

Supervised injection facility 'at an advanced stage...' SIMON HARRIS

Glasgow has an estimated 500 vulnerable people who inject in public places and has seen increasing rates of HIV infection. A business case will be presented to ADP in the autumn.

ALCOHOL ADMISSIONS UP AGAIN

THERE WERE 1.09M HOSPITAL ADMISSIONS FOR AN ALCOHOL-RELATED DISEASE, INJURY OR CONDITION IN 2014-15, up from 1.06m the previous year, according to the latest figures from the Heath and Social Care Information Centre (HSCIC). The number includes admissions where an alcohol-related condition was either the primary reason or secondary diagnosis. Sixty-five per cent of those admitted were men.

Alcohol-related deaths were up by 4 per cent to 6,830, 13 per cent higher than a decade ago, and more than 60 per cent were the result of alcoholic liver disease. The number of prescriptions related to alcohol dependence is also nearly double the amount ten years ago, at 196,000, and with a cost of almost £4m. However, just 38 per cent of secondary school pupils reported having ever drunk alcohol, the lowest figure recorded and down from 62 per cent when the survey began.

The statistics draw together published and unpublished data to provide a detailed overview of patterns of use, as well as a regional breakdown. The highest rate of admissions was found in Salford, at 3,570 per 100,000 population, while the lowest was in Wokingham, at 1,270 per 100,000.

The Local Government Association (LGA) called the figures 'shocking', while Alcohol Concern's director of campaigns, Tom Smith, said that the 'alarming' rise in admissions and deaths showed 'just how desperately we need the government to take serious action on alcohol harm'.

'Beyond liver disease, the public's understanding around alcohol harms is low – this is why we need action to raise awareness of the health harms, especially the increased risk of cancer,' he continued. 'To ensure the public better understand units and the risks associated with alcohol, we're calling for mandatory health warnings on alcohol products, as is standard practice in other countries. We also need a mass media campaign to make sure the chief medical officer's alcohol guidelines and the risks are widely known and understood.'

'Beyond liver disease, the public's understanding around alcohol harms is low – we need action to raise awareness of the health harms...'
TOM SMITH

Statistics on alcohol – England 2016 at www.hscic.gov.uk

GLOBAL PICTURE

THERE ARE NOW MORE THAN 29M PEOPLE CLASSED AS 'SUFFERING FROM A DRUG USE DISORDER' GLOBALLY, according to UNODC's 2016 *World drug report*, up from 27m the previous year. Around 12m people inject drugs, 14 per cent of whom are living with HIV, says the document. Although drug-related mortality has remained stable, there were still 207,000 reported deaths in 2014 – an 'unacceptably high number' and preventable with 'adequate interventions' in place, says UNODC. *Report at www.unodc.org*

ADAPTED APPROACH

EMCDDA HAS PUBLISHED ITS FIRST ANALYSIS OF THE HEALTH RESPONSES TO NPS, 98 of which were detected for the first time by the EU's early warning system last year. While existing interventions can be adapted to address NPS, 'competence-building' should be a key investment priority, says the document. 'The significant number of annual detections of these drugs, and associated harms, calls for the continuous assessment and development of appropriate services for users at risk,' said EMCDDA director Alexis Goosdeel. *Health responses to new psychoactive substances at www.emcdda.europa.eu*

NALOXONE NOTES

UPDATED GUIDANCE ON WIDENING THE AVAILABILITY OF NALOXONE has been issued by the government, covering issues such as who can supply the emergency overdose-antidote, using it to save a person's life without their permission, the risks associated with widening availability, and more. *Available at www.gov.uk*

'Alcohol marketing drives consumption, particularly in under-18s and sport should be something which inspires active participation.'

GROWING MARKET

CHILDREN WATCHING ENGLAND AND WALES matches during the group stages of Euro 2016 were exposed to alcohol advertising every 72 seconds, according to research by Alcohol Concern. Pitch-side adverts for tournament sponsor Carlsberg appeared an average of 78 times per game, says the charity, with around 14 per cent of the audience likely to be under 18. 'Alcohol marketing drives consumption, particularly in under-18s, and sport should be something which inspires active participation and good health, not more drinking,' said the charity's campaign manager, Tom Smith.

CRIMINAL STATISTICS

THREE QUARTERS OF PEOPLE IN THE UK'S CRIMINAL JUSTICE SYSTEM have a problem with alcohol, according to researchers at Teesside University, while over a third are alcohol-dependent – compared with just 4 per cent of the general population. 'In order to get appropriate interventions in place around alcohol we need to be working with practitioners and individuals involved in the criminal justice system,' said lead researcher Professor Dorothy Newbury-Birch.

BLACKPOOL BAN

COUNCILLORS IN BLACKPOOL ARE CONSIDERING IMPOSING A BAN on alcohol advertising in some areas of the town as part of their 2016-19 alcohol strategy, in a bid to address alcohol-related harm and crime. Blackpool has one of the highest rates of alcohol-related hospital admissions in England, while the north west as a whole has the highest rate of problem alcohol use. If agreed, the council could impose a new by-law by early 2018.

Blackpool has one of the highest rates of alcohol-related hospital admissions in England.

For the stories behind the news
www.drinkanddrugsnews.com

GOING PUBLIC

The UK's public health bodies have added their voices to the call for decriminalisation

Reports advocating the decriminalisation of drugs come along fairly regularly these days, but opponents of changing the law are usually able to say that it's just the 'usual suspects' making the call.

Last month's *Taking a new line on drugs* report, however, was more unexpected in that it's the work of the Royal Society for Public Health (RSPH) with the support of the Faculty of Public Health (FPH) (see news, page 4). The document gathered some favourable media coverage, including a front-page story in the *Times*, but some people might still be taken aback that organisations like this want to see drugs decriminalised.

'I don't think it should be a surprise,' RSPH spokesperson and the report's co-author, Ed Morrow, tells *DDN*. 'In the UK we're quite behind the debate if we look at what's happening internationally. That's the way the wind is blowing, with very positive and encouraging results in some places. We've now seen the World Health Organization, which is historically quite a conservative public health body, actually coming out and publicly saying that too much of a focus on a criminal justice approach is counter-productive and that we should be focusing far more on public health.'

The *Times* editorial went further and said that decriminalisation should be the first step to full legalisation. Is that something RSPH would back? 'At the moment the reason we're calling for decriminalisation, as distinct from legalisation, is that that's where the evidence lies,' he says. 'That's where we've seen the approach tried internationally with positive results. We're aware that there are potentially strong arguments to be made for full legalisation of certain substances, especially around having a product where people know what's in it, and taking supply out of the hands of criminal gangs. We think the evidence for that should be kept under review and we'd be interested to see what emerges internationally, but we think that what there is the evidence base for now is decriminalisation.'

As a public health body, however, what would they say to people who argue that it would mean increased levels of use, and therefore of harm? 'Well I think we just have to look at the evidence internationally, look at where it's been tried. We've seen no significant increase in use, and what we've seen go down is the number of problematic users and the number of people in their late teens and early 20s using drugs.

'I think we have to be pragmatic and acknowledge that no matter how hard we try to prohibit drugs, some people will always be unwilling or unable to stop using them,' he continues. 'We have to deal with the world as it is, rather than how we wish it was, and make sure that if people are going to be using substances to any extent then the amount of harm being done is absolutely minimal and that our health services aren't having to pick up the pieces later down the line.'

'We have to deal with the world as it is, rather than how we wish it was'

ED MORROW
SPOKESPERSON, ROYAL SOCIETY FOR PUBLIC HEALTH

The report doesn't just focus on the legal framework, however. It also wants to see responsibility for the country's drugs strategy moved to the Department of Health so that it's more closely aligned with the alcohol and tobacco strategies, and for 'evidence-based drugs education' to be a central, mandatory component of Personal, Social, Health and Economic (PSHE) teaching in schools.

While education is a 'hugely important' part of the equation, says Morrow, provision has been 'very patchy' and often not grounded in evidence. 'We know now that a "just say no" approach doesn't work and that young people don't tend to respond very well to that. It's much better to have a frank, open discussion about drugs and what the harms are, and that includes legal drugs as well. We think all young people in this country really have the right to that through PHSE education instead of putting themselves into dangerous situations by using drugs in some of the riskiest ways. Some parents who've tragically lost children to drugs have come out and expressed a wish that their children had been better educated about the dangers.'

The report contains much on drug-related harm and its impact on public health. However, many treatment providers have said that, since responsibility for public health was moved back to local authorities, drug treatment is simply not a priority for their local director of public health and that they've been sidelined when it comes to dividing up the money. What can be done to address that?

'This is part of a wider picture that goes beyond drugs,' he states. 'We know that funding is severely under threat and being constrained for all kinds of public health services at a local level, and we've been saying and lobbying on a national basis for a long time that this is a complete false economy and that it ends up costing more in terms of the health services picking up the pieces in the long-term. We acknowledge that there is an issue with funding and we're still doing all we can at a national level to say that these services need to be funded properly.'

Report at www.rsph.org.uk

More good practice stories at www.drinkanddrugsnews.com

A HELPFUL NUDGE

A partnership between Blenheim and Club Soda aims to change drinking habits

A set of digital tools has been developed through a partnership between drug and alcohol charity Blenheim and peer community Club Soda. Nudging Pubs includes an online self-assessment, where customers can review and vote for local venues that support those wanting to drink less.

The accompanying *Nudging pubs* report shares findings from a year of research with venues in Hackney, looking at how pubs and bars can accommodate people who want to drink less alcohol. It gives a picture of venues that want to do more, but lack ideas, time and space to make changes.

The report also reveals poor information for customers on making healthier choices, including non-alcoholic options, and shows a lack of shared understanding of what 'promoting sensible drinking' means in local authority licensing policies.

'We know that pubs and bars want to cater for the growing market of individuals drinking less alcohol, and we want to set the gold standard for what "good" looks like,' said Laura Willoughby of Club Soda, which supports people to change their drinking, whether they want to cut down or stop. 'Most importantly we want the customers to have the final say on which venues are the best. We think this product will do that.'

The initiative is being supported by Hackney Council, through their Healthier Hackney Fund, which helps organisations to test new ways of addressing major public health challenges.

'We hope that this initiative will empower customers, as well as pubs and bars themselves, to talk more openly about the choices and opportunities for people who want to drink a bit less alcohol on a night out,' said Penny Bevan, Hackney's director of public health. 'A quarter of 16 to 24-year-olds don't drink, so this is about making licensed venues better for everyone.'

> 'We hope this initiative will empower customers to talk more openly about choices...'

John Jolly, chief executive of Blenheim, welcomed the opportunity to innovate on a difficult issue. 'The project is an exciting opportunity for us to work with new partners and develop new tools to promote behaviour change with a wider audience,' he said.

www.nudgingpubs.uk and on Twitter @nudgingpubs

PROMOTIONAL FEATURE

PULSE ADDICTIONS

MADE TO MEASURE

It's time to ditch the 'one size fits all' approach and be ready to respond to clients' needs – whatever stage they're at says Dr Julia Lewis

'I ABSOLUTELY SWEAR BY IT' – a phrase normally prefacing someone's sure fire solution to weight loss, eradicating the 'soggy bottom' from your home-baked pies or some other conundrum of modern life. Some can be surprisingly evangelical about their guaranteed cure and cannot entertain the possibility that there might be an alternative, even backing up claims with a degree of pseudoscience. The history of addictions treatment has been peppered with similar stories and as practitioners you can feel that you need to pick a side, which changes as often as the seasons. 'Are we still recovery orientated?' 'Is it the chronic disease model now?' 'What happened to harm minimisation?'

Very often our particular allegiance is linked to the direct experience of our service users, yet what we practise is often determined by our commissioners. Gabrielle Glaser, author of *Her Best-Kept Secret: Why Women Drink – And How They Can Regain Control* recently criticised the way in which 12-step approaches are virtually mandated within the American healthcare system. And the situation within the UK is no different, with absurdities such as the commissioning of time-limited treatment programmes (because obviously everyone achieves recovery within the same time frame). The reality is, however, that we cannot have a 'one size fits all' approach as every service user is different and they all need a personalised response.

So, what's the answer? Well, firstly, addictions treatment has to move out of the realms of pseudoscience and into the bold world of evidence-based practice – we cannot pour scarce resources into interventions that have no proven effectiveness. Secondly we have to embrace person-centred treatment fully and be prepared to put aside our own hobby horses – we are not here to mould service users into specific treatments because they just happen to be the ones we have on offer. We are here to ask the question, 'what would a good life look like to you?' and then support them to make those changes.

A 'one size fits all' approach is ineffective. We need to use the whole array of skills to provide the best service to each individual – and that means ensuring those working in the addictions field are sufficiently supported, challenged and empowered through evidence-based training and effective regular supervision.

Pulse Addictions provides tailored training, consultancy and clinical management in the field of substance misuse and associated areas to organisations across the UK. With a proven track record of developing services, whether community based, NHS, third sector, private sector, residential or secure, they have the expertise to meet the most demanding of briefs with a personal touch.

Dr Julia Lewis is medical director at Pulse, www.pulseaddictions.com

Behind

Enduring adversity in childhood presents both challenges and opportunities in later life. But it is known that experiencing significant trauma in childhood considerably increases the risk of misusing drugs and/or alcohol. Research tells us that our early life experience programmes the brain and the body for the environment that it encounters. So a calm, nurturing childhood is likely to orientate a child to thrive in most conditions, while a highly stressful, bleak, abusive one will predispose it to conditions of anxiety, insecurity and chaos. What is interesting is why some individuals do not suffer from addictive behaviours and mental health problems, while others do.

Abuse and trauma in childhood take many forms and are categorised under physical, emotional and sexual harm. Much under reported but very common, is the impact upon children of a low level but pervasive parental vacuum, where there is a significant absence of real parental engagement. This can be because the parent is preoccupied with their own problems, such as depression or mental illness; or it can be because they are dangerously immature, and therefore more concerned with having their needs met than nurturing their child and overseeing their teenager. Even more damaging to a child can be the chronic recurrent humiliation of emotional abuse – being told that you are useless or not good enough.

The term 'child' refers to pre-birth from the time of conception, through to the age of 18. Some parents consider that their role as vigilant and nurturing carers ends when their child reaches ten or 12 years. But young people require love, care and actual parenting until they are adults themselves – and beyond. Many young people find themselves becoming increasingly involved in drug and alcohol misuse, but this can be overlooked, minimised or rationalised by a parent until it is too late.

'Much under reported but very common, is the impact upon children of a low level but pervasive parental vacuum, where there is a significant absence of real parental engagement.'

In my 35 years of practice in this field, the most common factor I have come across when talking to those suffering from substance misuse and mental health problems, is that there has been some very significant trauma in their lives that they have not fully revealed before, and certainly not recovered from.

Research bears out that those who misuse drugs or alcohol have so often been victims of sexual abuse. Such victims suffer post-traumatic stress disorder leading to poor coping skills, anti-social behaviour, depression, anxiety, low self-esteem and problems in forming trusting relationships. Substances can be used to cope with or escape the trauma and memories of sexual abuse, and as a way to reduce a sense of isolation and loneliness. They become a form of self-medication, to boost confidence and improve self-esteem, or a form of self-destructive behaviour and self-harm. Either way, an individual has raised the red flag asking for help, and as practitioners we need to respond quickly.

A significant percentage of those who have a substance misuse problem also have a recurring mental disorder such as depression, anxiety and/or post-traumatic stress disorder. Process addiction, such as gambling, disordered eating and internet addiction, has been found widely in those who report childhood sexual abuse. Of course one of the difficulties of this kind of abuse is the difficulty for survivors in acknowledging and reporting it, and it is also difficult for caregivers to identify.

Research confirms that the more adverse childhood experiences encountered, and the higher the types of stress, the greater the odds are of an individual suffering with later life addiction. The adverse childhood experiences (ACE) study included 17,000 participants and found multiple relationships between severe childhood stress and all types of addictions, including under and over-eating. These adverse experiences included emotional, physical and sexual abuse, neglect, and living in a house where domestic violence had taken place. Compared to a child with no adverse childhood experiences, one with six adverse or more experiences is nearly three times more likely to become a smoker as a child; a child with four or more is five times more likely to become an alcoholic and 60 per cent more likely to become obese. A boy with four or more ACEs is 46 times more likely to become an IV drug user in later life than one who had no severe childhood experiences.

An adult survivor of child sexual abuse cannot be categorised easily. There are complex dynamics at play and deep trauma at work. Generally speaking, adults will normally have one or two outlooks on life after such abuse. They will either collapse or they will attempt to rise above the abuse. The collapsed outcome is an adult who has easily recognisable symptoms and problems that stop them from being functional in more than one area of their life. They have depressive, addictive or victim status personas, and require ongoing medical and other assistance to cope.

The second outcome often includes those who dissociate from the abuse by 'soldiering on' and maintain, for some time, an intact functional life in work and

More on mental health at www.drinkanddrugsnews.com

closed doors

Encouraging clients to talk about their childhood can help to release them from the long-suppressed trauma of abuse, as psychotherapist **Elaine Rose** explains

social settings. But they often withdraw or have serious impairment issues in intimate relationships.

Behaviours and coping mechanisms common to both groups can include impulses to abuse another person in some way; promiscuity, frigidity, suicidal thinking, self-mutilation or absence from relationships. There is also a body of evidence that psychosomatic medical disorders often accompany sexually abused children later in life. Survivors can experience unexplained pelvic pain, irritable bowel syndrome, cervical cancers and rashes. The issues are complex.

The good news is that the same key factors which cause some people to misuse drugs and alcohol also provoke resilience, ie coping with chronic stress and coming through it, developing inner controls and self regulation when provoked. The same factors spur recovery from addiction, finding and maintaining social support, developing a confiding relationship with someone, becoming a loving partner or parent, and being involved in groups or religious organisations. Safe, familiar people in whom an individual can confide buffer against stress since our stress systems are designed to be calmed down with a nurturing word or touch from someone we trust.

It takes courage to talk about an adverse childhood experience, especially when it may have become muddled or confused, and particularly if it was a sexual experience. Encouraging individuals who are suffering as substance misusers to speak about their early life experiences is often the start of helping them to become released from the burden – and the real beginning of the healing process.

Elaine Rose is a child and family psychotherapist with a background as a social worker. She is in private practice in Kent, specialising in work with all in the adoption triangle.

BREACH OF TRUST

With the help of One in Four's Survivors' Voices Project, *Gerard* shares his devastating experiences – a process that has helped him to engage with therapy and start to rebuild his life

I WAS SEXUALLY ABUSED BY MY MOTHER. Every part of me felt ruined by this, all the way through me, right to my soul. I thought I was the only one. It was something I was certain I would never and could never speak about. I didn't even see it as sexual abuse when I was a child as I only heard of uncles abusing or perverts in parks, not a female, let alone a mother, so I saw myself as having the most vile, terrifying and disgusting things happen to me.

But it must have been my fault because it never happened to anyone else in the world ever, and that's why I thought I was the most disgusting thing on the planet. Even though I tried to stop it in any way I could think of, I was also dependent on this person for my life, food and shelter.

My first memories of it were as a five-year-old and I still can't get the contaminated feelings and taste out of my mouth from what she made me do.

I feel I didn't have a childhood. I have felt so horribly isolated and alone in a world that was unsafe, especially at home in any room, at any time. I tried to speak out when I was five, but nothing was done and it just made it worse, as I was told by my mother that no one wanted to know and no one would believe me.

As a young child I felt completely different to everyone else. I knew I only had myself to depend on. I cannot remember any moment in my childhood being truly happy.

Self-annihilation, utter isolation, shame, self-disgust, extreme trauma, anxiety, depression and anger are all things I have lived with throughout my life; with the resulting self-harm in many forms through having no value to my life, and addictive tendencies to keep away from my inner reality and beliefs.

Waking up screaming in the middle of the night or not sleeping at all for very long periods, or indeed being overwhelmed with flashbacks, visual and non-visual, day and night, as if in my worst nightmare, and resulting suicide attempts. These were all my symptoms of complex post-traumatic stress disorder.

The horror of the years of abuse, which was emotional and physical also, at times torturous on all levels, still haunts me. The horrid, contaminating, vile, and most disgusting thing that could happen and the betrayal by the person who brought me into the world – breaking what I believe should be a sacred bond.

One in Four provides support and resources for those who have experience of sexual abuse, www.oneinfour.org.uk

More on jobs and careers at www.drinkanddrugsnews.com

'Addiction nursing in 2016 is a very different job compared to ten years ago... the time has come for addiction nurses to find their voice, and with it their value.'

HOW I BECAME A...

SUBSTANCE MISUSE NURSE

Making a positive change to someone's life has been a motivating force for **Ishbel Straker**, national head of nursing for substance misuse and public health at Turning Point

I never thought I would become a nurse – law was my initial career choice. But during my training to become a barrister I worked on a dementia ward to pay for my tuition fees. That was when I began to realise that I couldn't envisage doing anything else.

I studied mental health nursing at the University of Central Lancashire and during my course I began to plan for the future. I knew I would be moving to London and wanted to gain some substance misuse experience.

I requested my elective placement be within this setting and went thinking, 'I'm not going to like this.' How wrong could I have been! From the first day I stepped into Skelmersdale alcohol service my career pathway changed and I never looked back.

It was a combination of the client group and the people I worked with. My mentor was very influential, as was the team he worked with. It was a small community service but their passion for clients taking responsibility and being the masters of their own destiny was infectious. It was simple and so effective.

Once qualified, I went into work in a number of NHS community services in the north and then moved to London, where I worked in my first non-statutory service. It was another pivotal moment when my eyes were opened to non-NHS services that are doing an amazing job for their clients, and I went on to work in a number of these organisations, both inpatient and community. I gained my V300 and practised as an independent prescriber within each role.

I came to Turning Point in 2014 as a nurse manager within a newly contracted integrated service. It was an exciting time as we had the opportunity to shape a service and I learned some important lessons, including how to manage new contracts with existing staff and clients. Acknowledging people's abilities and tapping into existing ways of working is essential.

When the role of head of nursing was advertised, I went for it. My reasons for applying were my passion for addiction nursing and my disappointment at where it has gone over the years. Nurses have become disempowered and lost their identity because of the tendering process, but I feel strongly that they must be able to provide the broad skills they have to service users – they deserve the best that we can give them.

Addiction nursing in 2016 is a very different job compared to ten years ago. There have been many changes and the profession has been reformed numerous times. However, the time has come for addiction nurses to find their voice, and with it their value. I'm an active member of the Substance Misuse National Prescribers Forum and The Royal College of Nursing, and a board member of ANSA.

I meet regularly with my ten nurse managers to discuss and ensure high quality care is being provided and see how we can make improvements. Part of my role is to support the next generation of nurses in having an understanding of addictions, and I have regular contact with local universities setting up links and pathways for students and preceptors.

I really enjoy what I do because no day is ever the same. I could be in London or Manchester attending business planning or clinical meetings, or I might be visiting one of our services, linking with the nurse manager, operational manager and clinical lead. At one of these visits, I may observe some clinical practice and ensure compliance through auditing a clinical area, notes or care plans. As an Independent nurse prescriber, I might have a clinic booked which is one of my favourite things to do.

I also attend conferences and work with a number of national nursing organisations that deal with addictions, developing wider policies and standards. I work very closely with our medical director and we align our decisions with the clinical team.

In all of this, the most important thing to me is client care and my motivation is providing services that I would be happy for my loved ones to attend. My sole purpose as a nurse is to make a difference, no matter the size of the difference. This remains my driving force – I want to be an intrinsic part of a positive change in someone's life.

Share your career path

email DDN editor, claire@cjwellings.com

Cry for help

Painkiller addiction is a growing issue. In the first of a three-part series, DDN asks, are we responding?

Painkillers are a growing market and prescribing is on the increase. Drug services are seeing a growing number of people presenting with opioid painkillers as their drug of addiction. But despite local statistics and plenty of anecdotal evidence, there is no national picture of how big the problem is – and no coordinated strategy to deal with it.

'It's really impossible to try to assess the scale of the problem,' says Duncan Hill, specialist pharmacist in substance misuse at NHS Lanarkshire. 'There's a real gap in evidence, but it's a massive problem in America and prescribing here is on the increase.

'It's a really challenging issue and one of the problems is trying to quantify it. There's just no data. You could be misusing over the counter (OTC) stuff, or you could be getting it from friends and family, or you could be going to the doctor and getting it prescribed. It's multi-access, multi-source – there's a mass of different methods of getting the medication.'

As a community pharmacist in north west London, Stephanie Bancroft is well placed to take stock of the situation, seeing patients who are picking up prescriptions from their doctor; people who are buying OTC painkillers – both 'pharmacy only' (P) medicine at the chemist's counter; and 'general sales list' medicine (GSL) at the till.

'Quite often patients are put on an opioid-containing painkiller by their doctor and then it's put on repeat without being reviewed,' she says. 'The patient continues to take it but might not need it – it could be titrated down to a less potent medication.'

Then there's the patient who actively seeks opioid painkillers from the doctor or pharmacist when they are no longer in pain. 'They are the ones that are more likely to be addicted, because they don't understand that they don't need this pain relief anymore. Their brain is telling them, "I want the opioid high", which is very difficult to address. They may also feel uncomfortable or unwell when not taking painkillers because of withdrawal effects.'

Recognising the problem is the first step, she explains, which means being able to identify the difference between someone deliberately misusing the drugs and a person who has become addicted from long-term use.

'You do get people who will do anything to get medicines, trailing round ten pharmacies to get a pack of 16 or 32 painkillers maximum from each to feed their habit,' she says. 'But if you refuse to sell them the product, you know that they're going to do down the road to get it from somewhere else, or go further afield so that they're not recognised.

'Then there's the patient on a prescription who has a two-month supply of painkillers, but comes back after seven weeks, then six weeks, saying they've run out. Quite often they come up with excuses – they've lost them, they've given some to family members, they've left them on holiday. I've heard it all.'

An experienced pharmacist can spot opportunities to intervene, but even with years of experience Bancroft acknowledges that this isn't easy and needs high-level consultation skills.

'Often they don't accept there's a problem and they don't want to talk to you, so breaking into their world is very difficult. How do you suggest that the patient has a problem without appearing to be interfering? Some people have the knack but others dive in and alienate the patient,' she says.

Pharmacists are supposed to ask the WWHAM questions, she points out, which stands for who is the patient, what are the symptoms, how long have you had the symptoms, what action has been taken, and are you taking any other medication. They also need to counsel the person about side effects of the drug and the fact they should not be taking it for more than three days, but 'there's no guarantee that that's happening in every single case.'

The other crucial issue is referral. 'If you do identify a patient who you think has got a problem, there's nowhere really to refer them to,' says Bancroft. 'You can't do it as a pharmacist, you'd have to refer them back to the GP.' Of course there's the drug and alcohol team – 'but quite frankly a patient who's got this type of addiction doesn't want to be attending a drug and alcohol service, because they don't see themselves as addicts or abusers,' she says. 'They regard themselves as normal people who just need to take some tablets.'

Up in Lanarkshire, Duncan Hill's team have been trying to get heads together on the growing problem of opioid painkiller dependence.

'There are some discussions between primary care GPs and pharmacy leads with addictions, and we've also had some conversations with the chronic pain services, but we're not as far engaged as we'd like to be,' he says. 'But we have been trying a couple of small pilots with GPs, providing support, and have started to develop tools.' The aim of this, he explains, is to help GPs to review and reassess the patient, and to address their issues. The tools help to sit down with the patient and look at what was originally prescribed, what it was for, and find out if they still have the same condition and the same pain – as well as reviewing all the medication that they are currently taking and finding out if there are other reasons for taking it, such as to help them sleep better.

> 'It's a really challenging issue and one of the problems is trying to quantify it. There's just no data.'

'We need to provide support mechanisms,' says Hill. 'We have to be aware that we need to treat the pain as an everyday occurrence for most patients and keep it at manageable levels. And we have to treat it no matter what else is happening in the patient's life.

'What we need to do is bring all the people with an interest in this around the table and try and work out the best way.'

More on painkiller addiction at www.drinkanddrugsnews.com

'I THOUGHT I WAS TAKING CONTROL'

Cathryn Kemp took pain relief into her own hands, until she realised her addiction was killing her. She talks to DDN

In 2004 I was literally hit overnight with acute pancreatitis, and over the next four years I was in hospital about 40 times. As an inpatient I was treated with IV morphine and tramadol and then as an outpatient I was given oxycontin.

I was moved up to a London hospital at the end of 2007, where they switched me onto IV fentanyl, because the morphine had exacerbated my condition, making me even more ill. I'd had lots of surgery, lots of procedures, and was eventually discharged in 2008 with a repeat prescription for fentanyl lozenges [opioid analgesics], being told I could have eight a day as a maximum.

It took me about three months before I took an extra one – and I don't know why I did. I'd had years of being operated on, diagnosed, misdiagnosed, and I had no control whatsoever over my journey. So for some weird twisted reason I felt I had taken back control of my life by taking an extra lozenge for the pain. But actually it was the start of a terrifying descent into drug addiction.

This was in 2008 and by the time I got to rehab in 2010 I was on 60 lozenges a day, all on prescription from my GP. He'd told me that he wouldn't sign any more prescriptions and I hit desperation.

I was refused NHS detox because I wasn't homeless and I wasn't offending. There's a massive loophole in the system and I fell right through it. My parents had to lend me lots of money, and I had to sell my house.

I was lucky I had a house to sell, or I would be dead. But how many people are there out there suffering in silence, with GPs not taking the fact they're dependent seriously? GPs who feel that taboo about having patients who are on long-term opiates and having no other way of treating them, but knowing they are dependent on them.

It's a really complex issue – you get pain and you get the denial of addiction, and when those two are working together it's incredibly difficult for anybody to make any headway. That's one reason we set up a charity, the Pain Addiction Information Network (PAIN), to say 'if I can get off these, then almost everybody else can'. It's to raise awareness of OPD, recognised by the World Health Organization and is as much about stigma busting as saying 'this is something that can happen, so what are we going to do about it?'

> 'I was refused NHS detox because I wasn't homeless and I wasn't offending. There's a massive loophole in the system and I fell right through it.'

We're campaigning to have specialised services to help people who find themselves dependent on their prescribed or over-the-counter medication, and we want NHS England to provide specialised treatment services for patients who come in via pain, rather than via illicit drugs.

Find help at: www.painkilleraddictioninformationnetwork.com. Cathryn Kemp's book, *Painkiller Addict: From Wreckage to Redemption*, is available from www.painkiller-addict.com

Opioid Painkiller Addiction Awareness Day (OPAAD) is on 22 September

Read the full stories and more:
www.drinkanddrugsnews.com

'This sector has a unique talent for pessimism, which is at odds with its strong track record of helping achieve positive change in complicated lives.'

REASONS TO BE CHEERFUL

Paul Hayes is determinedly upbeat in the aftermath of Brexit

The country currently has no government, no prime minister, no opposition, no friends, and may soon disintegrate – and that's ignoring the football!

As we pass through the most profound political crisis since the war, what are the implications for the alcohol and drug treatment sector?

Even in a situation of maximum uncertainty, two assumptions seem reasonably robust: there will be less money and declining political interest. The referendum offered two visions of the economy post Brexit – lower growth leading to lower tax revenues feeding through into lower public expenditure, or a Britain unleashed as a dynamic low tax, low spend, low regulation economy. Neither of these suggests imminent decisions to devote extra resources to marginalised 'undeserving' populations.

Just as significant, the amount of national political interest in our sector is likely to shrivel. For the foreseeable future Westminster and Whitehall will be obsessed with the mechanics of Brexit. The chances of political time and energy being focused on addressing alcohol and drug treatment are negligible.

Tactically this may have some short-term value. There has been a lingering threat to evidence-based treatment since 2010; the absence of political interest may therefore be helpful in preventing renewed ideological attacks. But solving the underlying causes of dependence which are rooted in inequality, or addressing the structural deficits in the system – access to mental health services, jobs, houses; the disconnect between prison and community services; drug-related deaths – would require consistent, committed political leadership over many years. This is not going to happen.

So where does this leave us? In a much better place than most of us think. This sector has a unique talent for pessimism, which is at odds with its strong track record of helping achieve positive change in complicated lives. So the first thing we need to do is reflect on our strengths and attributes.

England has a world-class treatment system delivering rapid access to evidence-based interventions for a higher proportion of our population who need it than almost any equivalent country. This has yielded major reductions in heroin and crack addiction, very low levels of HIV infection, and declining drug-related crime.

Despite static funding between 2008 - 13 and reductions of around 25 per cent since, investment in drug and alcohol treatment has still doubled since 2001.

We have a wealth of intelligent skilled and committed frontline staff. Over the past decade, the ability of middle managers and senior leaders to understand the environment in which they operate, motivate staff to deliver, and provide a clear sense of direction, has improved significantly.

The sector has learned how to draw on the knowledge and experience of service users to enrich the quality of delivery. This is now deeply embedded and is key to current and future success.

There are key allies in Whitehall. The Home Office continues to see treatment as one of its most effective interventions to reduce crime. The chief medical officers of the UK and NICE are stout defenders of current evidence-based practice. NHS leaders understand the role of alcohol and drug treatment in diverting long-term cost pressures from their hard-pressed services.

So how do we begin to deploy these resources? Assuming there is no direct ideological challenge to the evidence underpinning our success, the biggest threat comes from a series of local decisions to de-prioritise and disinvest by local authorities and their partners. These will impact negatively on a population becoming more vulnerable as it ages and also suffering from the cumulative consequences of austerity.

This presents twin challenges to the sector. Firstly we have to find a new narrative, as persuasive to local authorities as previous harm reduction and crime led narratives have been to central government. This needs to be a shared endeavour across the sector, service users and our allies in Whitehall.

Secondly we need to challenge ourselves to become ever more innovative to protect and improve outcomes in a climate of reducing budgets. Experience suggests that this is more likely to be achieved by a workforce that is optimistic, motivated and well led then it is by managers and staff who are consistently reminded of how powerless they are as they struggle in the face of 'the cuts'. However if working smarter is genuinely to be more than rhetoric, we also need to learn as a sector what genuinely can't be achieved and to walk away from contracts that are offered at a price that cannot sustain outcomes.

Collective Voice is keen to work with the wider sector to fashion this new narrative and gain better understanding between all parties, but particularly commissioners and providers, of the scope for innovation and the point at which cash savings in one part of the system create greater cost pressures elsewhere. Our series of events in September for service users, NHS and third sector providers, commissioners, and young people's services – which will include officials from the Home Office, Department of Health, PHE and local government – will look at how we can best protect what has already been achieved and respond to the new challenges we face.

Paul Hayes is head of the Collective Voice project, www.collectivevoice.org.uk

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.

'Addiction to drug and alcohol takes a heavy toll on society. I have seen the impact over 22 years from crime, worklessness, the strains on the NHS and the price paid by individuals and families, but I have also witnessed hundreds of people transform their lives.'

SIGN ON THE LINE!

A war on drugs has been declared in Staffordshire as the county council propose to slash funding for drug and alcohol services by 59 per cent. Alcohol and drug treatment and rehabilitation services in the county have come together with services users, family members, politicians, celebrity supporters such as Russell Brand and Mitch Winehouse and members from across communities in Staffordshire, to fight these proposals.

They hope that once the serious consequences and the devastation this will have on communities across Staffordshire is understood, the council will reconsider and work with the agencies to ensure the needs of local individuals, families and communities are met.

Addiction to drug and alcohol takes a heavy toll on society. I have seen the impact over 22 years from crime, worklessness, the strains on the NHS and the price paid by individuals and their families, but I have also witnessed hundreds of people overcome their addiction and transform their lives to become productive members of society.

A number of services have contacted us, expressing not only their concern for Staffordshire but also about other local authorities expressing their intentions to make huge cuts to budgets. We were always concerned about funding for drug and alcohol treatment and rehabilitation when the ring fence came off the budget, but I never imagined that councillors would cut budgets to these vital services by more than half.

The consequences will be far reaching for individuals, families and communities. The work undertaken by drug and alcohol agencies reduces crime, pressure on our already stretched A&E and hospitals, reduces the number of children on the at-risk register, to name a few, but most importantly it saves lives and re-builds families.

As a result we have started a petition in Staffordshire and want enough signatures to get the issue debated in Parliament as to why the ring-fence came off drug and alcohol treatment and rehabilitation budgets. These services are as vital as many other NHS services that have been protected. Therefore it is essential that everybody signs this petition and encourages staff, clients and family members to do the same.

The petition can be found at https://staffordshirerecoverymatters.wordpress.com/

Noreen Oliver, founder and CEO of The Burton Addiction Centre and founder and chair of RGUK

COUNTERPRODUCTIVE CUTS

In Bournemouth we had a day centre that was open all day for the homeless. We did activities such as cooking, art, group chats (usually serious), coffee and chats (usually lighthearted), strawberry picking, photography competitions, quizzes, cinema outings, service user involvement, an extensive diversity calender full of famous people's birthdays or important dates (some fun, some serious) as well as assessing people for housing.

We had a daily doctor, weekly mental health nurse (who would also come out other times if needed), weekly podiatrist, weekly blood-borne virus nurse, and a dentist. We would also refer to the drug and alcohol teams. We tried to fill each day with something.

Since the council decided to close it, the amount of drug and alcohol use in the town has escalated, which also means more begging and crime. Police are caught up in almost petty stuff, then the courts and prisons are full with people for short sentences – no time to be rehabilitated and no staff even if they were there longer. Bournemouth cut the day centre to save money. The actual cost was about £25,000 a year. (There was only one paid member of staff. All the outings were paid for by car boot sales from donations and the service users helped out, meaning they were trusted and felt valued.)

The service users were involved in things – their opinions counted. We even had litter collecting mornings with local police community support officers which built up relationships – both ways. Now the same people sit in shop doorways and parks, heavily under the influence, which affects the town. They are so bored and need something to numb their reality – drugs and alcohol do that.

The supported housing providers want them to address their using, drinking and begging, so some would rather sleep out than live there. I'm not saying the day centre was perfect. It wasn't.

More staff would have helped. But it helped make street homeless feel part of society for a short while. When a young, homeless female sitting in an Orange Wednesday cinema seat, eating Asda's own popcorn, drinking Asda Cola, looks up and says 'I feel so spoilt', then you know something good is happening. If she hadn't been there she would've been selling her body to raise money for drugs.

Keeping active surely must be a massive contributor to staying away from mood-altering substances. Minds need to be occupied. Bournemouth council took that away.

Sally Howells, via DDN magazine Facebook

HELP US HELP

The long-awaited DDN Help resource is now ready to go live, but we need your help before the official public launch.

This new free online treatment finder will allow people looking for help with drugs and alcohol to locate the best service for them. This might be anything from the nearest needle exchange, a local support service, or a five-star residential rehab based overseas.

Set up to work quickly and easily on mobile, desktop PCs and laptops, the new resource offers a location-based search, as well as the ability to filter the response. This is just the start – the new site will be a free source of information for anyone looking for help for themselves or a loved one.

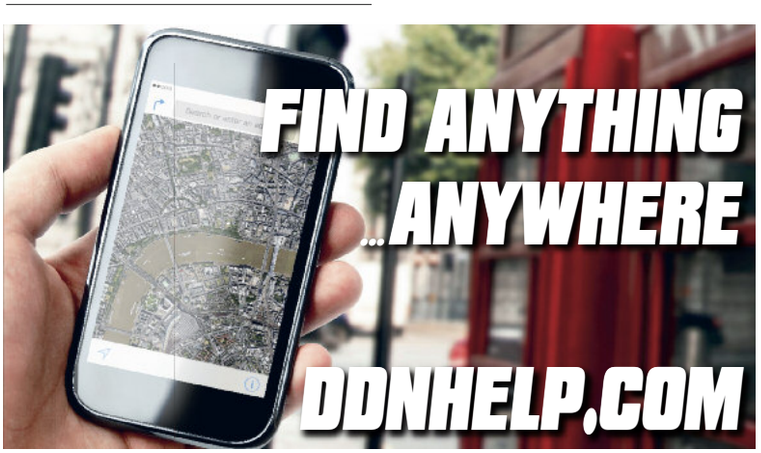
DDN Help is free to both the end user and to services wanting to add themselves – if you run a rehab, day programme, recovery group, or community pharmacy or offer therapy or counselling, you need to make sure you are on our listings. This resource will only be as good as the information it holds, so please join us and make sure you're part of it.

Visit www.ddnhelp.com today for details on how to add your listing.

DDN magazine and DDN Help are keen to partner with all organisations in the field offering information and support. If you would like to discuss any opportunities or ways in which *DDN* and your service might work together, please contact me – ian@cjwellings.com

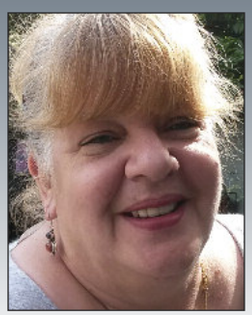
Ian Ralph, DDN

DDN needs your help to launch our new free service at www.ddnhelp.com

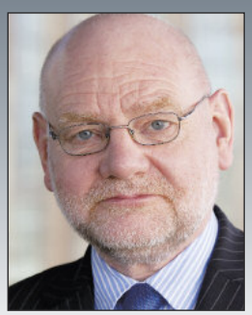


FORCE

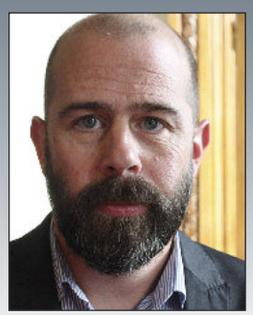
How can we develop our workforce against a backdrop of cuts and challenges? *DDN* reports from the FDAP conference



CAROLE SHARMA, FDAP



PAUL HAYES, Collective Voice



PETE BURKINSHAW, PHE

'Services are now expected to do more with less while caring for individuals with increasingly complex needs,' said Carole Sharma, chief executive of the Federation of Drug and Alcohol Professionals, opening FDAP's annual conference for workers in the sector.

So how could we drive workforce development to make sure that it was relevant and effective?

First up was a well-known figure, Paul Hayes – formerly head of the National Treatment Agency (NTA) and now leading Collective Voice, representing treatment providers.

'If we're despondent about the state of the sector, odds are we're going to be under-serving people,' he said. 'People say to me, can't we have the NTA back – people who wanted to hang them from the nearest lamppost... but we have to get much smarter at tapping into a new narrative.'

Commissioners needed to be driving innovation and we had to make sure people had the skills to deliver. 'We need to focus relentlessly on delivering outcomes,' he said. 'The most significant challenge for all of us is deaths – they're going up very rapidly. We have to be ready to change our practice.'

Hayes acknowledged the climate of uncertainty, with no sign yet of when the drug strategy would come out.

'Is all this easy and comfortable? No. But it is possible and necessary,' he said, adding 'If you think we're all going to hell in a handcart, get out of this game.'

'Nothing was ever positively done from despondency,' said Pete Burkinshaw of Public Health England (PHE), who was keen to emphasise the sector's 'rich evidence base'. Another reason to be cheerful was localism, he said, as it 'makes all of you much more important'.

But with a growing cohort of people with complex needs, we had to develop specific competencies to manage the risks faced by service users.

'Your doors need to be wide open to engage with need,' he said. 'Services can't be a reflection of what we do, what we're comfortable with and have always done. What you need is workers who have techniques and have belief in those techniques.'

As well as a set of universal core skills, workers needed meta competencies – and to 'know when and where to do and not do things' – an important element of adaptive and purposeful treatment.

FDAP had asked two of the larger treatment agencies how they prepared an effective workforce, so the conference heard from David Bamford from Change, Grow, Live (CGL, formerly CRI) and Guy Pink from Addaction.

Pink believed it was 'a really good time to be in the sector' and described Addaction's guiding principles as being 'collaborative, ethical, inspiring, resilient and self challenging' – 'a team-based approach'.

'We want people to be driven by integrity,' he said, 'so we recruit and manage against these guiding principles.'

The organisation was constantly reviewing challenges and solutions, looking at different patterns of working and ways of increasing productivity.

'We're doing more for less, but we have a good pool of workers,' he said, emphasising that they did not want to be among the two thirds of the workforce who were disengaged. 'We all know that people don't

NEW PARADIGMS

We need to go beyond training to tackle workforce development, says Professor *Ann Roche*

The workforce is without doubt the most important element in addressing alcohol and other drug (AOD) related problems.

Without an appropriately skilled, competent and confident workforce able to execute evidence-based interventions and policies the AOD sector will always be hampered in its efforts to prevent and ameliorate the ever changing array of issues. Ensuring that our services, programmes and policies offer best available options requires our workforce to be able to function to maximum effectiveness in increasingly challenging environments.

Traditional thinking has relied heavily on training as a mechanism by which to achieve optimal service delivery, but while training is a necessary component in this complex picture, it is insufficient in itself. Research increasingly indicates major flaws in the 'train and hope' approach to knowledge transfer and innovation dissemination. That is, training often fails to deliver the ultimate expectation and goal – ie behaviour change. This is through no fault of the individual worker, as a multitude of factors are at

Find more on workforce at:
www.drinkanddrugsnews.com

FOR CHANGE

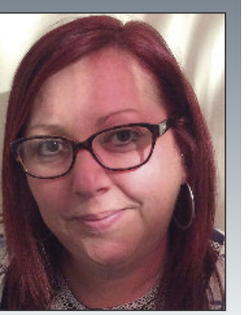

DAVID BAMFORD, Change, Grow, Live


GUY PINK, Addaction


SUNNY DHADLEY, SUIT


SAM THOMAS, Making Every Adult Matter


OLIVER STANDING, Adfam


PATTI BODEN, CQC inspection manager

leave organisations, they leave managers,' he added, 'so we've put a lot into improving managers.'

'What's difficult for staff to feel they manage is multiple requests from a lot of people wanting loads of different things,' said Bamford. 'We need to develop a growth mindset for our staff, as that's what we want for people they work with.'

CGL believed that 'top down doesn't work', he said. 'We know that most people are interested in what's going on around them or their first line manager. It's pointless pitching things top down.' So a flat hierarchy needed to go hand in hand with things that increased reliability – awareness of risk, expertise and the ability to adapt to the unexpected.

Staff were encouraged to reflect, plan, act, observe and evaluate, and were introduced to the 'dreaded drama triangle' during training – an illustration of how a worker can become a 'rescuer, victim or persecutor' in the workplace and recognise what triggers the situation.

'Profound simplicity, such as five ways to wellbeing' was also an aim, he said, 'because simplicity of focus is effective.'

There was a positive side to being asked to do more with less, said Bamford, in that they were 'also doing more with more – linking with people we've never linked with before.'

He also had questions for FDAP: 'What are the shared values for the field?' and 'How do we extend the ladder of professional support to include the peer mentoring community?'

Sunny Dhadley, manager of Wolverhampton's Service User Involvement Team (SUIT) was speaking next, and well placed to offer answers. He set up SUIT ten years ago, while still in active addiction and began attending meetings 'where people were saying the same old rhetoric'. He realised that by sharing knowledge between his peer-led organisation and the workforce, they could develop competence and make treatment more compassionate.

'We have a fantastic treatment system in this country and should be very proud of it – but we need to look at ways of doing more,' he said.

'Initiatives don't need to cost the earth – we draw upon resources in society,' he explained. With an annual budget 'that costs less than sending an adult to our local cat B prison', SUIT has worked with 522 different agencies and supported 146 people back into work in the past five years, as well as offering 'a huge range of activities'. Top ten interventions have related to welfare, employment, education, emergency food, volunteering, housing, IT, healthcare, criminal justice and treatment.

'We see a huge amount of inequality and low levels of literacy and numeracy,' he said, mentioning that 24 per cent of prisoners had been in care as a child, with many having the English and maths skills of a primary child, so there were 'high levels of vulnerability'.

We needed to ask, 'what are we doing to support people's dream happening?' he suggested.

Sam Thomas from Making Every Adult Matter (MEAM) added to the picture of working with people with multiple needs, talking about the 'sheer complexity of the world that clients are trying to make sense of and that practitioners are trying to make work'.

Around half of people with substance misuse issues also had another problem such as offending or

play when attempting to change workers' behaviours.

In recent times an important paradigm shift has occurred, as training has been reconceptualised with the broader, more diverse and more comprehensive concept of 'workforce development'. This is a multi-faceted approach, which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to alcohol and other drug-related problems.

Workforce development should have a systems focus; unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational, and structural factors, rather than just addressing education and training of individual mainstream workers.

Without tackling the broad array of systems factors that determine and shape what workers and services can do we will be forever limited to ineffective, costly and inappropriate responses. A workforce development approach that incorporates a systems perspective allows issues related to social equity and work conditions, government policies and organisational structures to be seen as central. It then allows other factors such as worker wellbeing, recruitment and retention, career pathways, supervision and support to be addressed as pivotal concerns in regard to knowledge and skill transfer.

Without taking this broader approach, transient training programmes will continue to soak up limited funds and produce relatively modest, if any, change in services and programs.

Although it may seem counter-intuitive that training alone cannot deliver pressingly needed changes and supports to our crucial AOD services, the evidence is abundantly clear. Training is, and will always be, only a small part of the solution. A broad and comprehensive workforce development approach that focuses on systems issues is what is required.

For further details and resources visit NCETA's website: www.nceta.flinders.edu.au

Professor Ann M Roche is director, National Centre for Education and Training on Addiction (NCETA), Flinders University, South Australia

‘We have to get much smarter at tapping into a new narrative’

PAUL HAYES

‘We’re doing more for less, but we have a good pool of workers’

GUY PINK

‘We can get bogged down in numbers and targets... we need to focus’

FIONA HACKLAND

homelessness, but we were ending up with services that dealt with one problem at a time.

‘We have a system that deals with numbers, but behind every number is a human being,’ he said. The MEAM project, *Voices from the frontline,* was trying to build a better dialogue between people making decisions and those affected.

‘This often requires people to work in a way they may not have thought about or feel comfortable with,’ he said.

The family workforce could be an important part of this, said Oliver Standing from Adfam, who challenged the perception of families being ‘a bit of an add-on’.

‘The family workforce can be hard to pin down – they could be a service, a standalone community group, a carers’ centre, volunteers, drug and alcohol workers or a generic service – there’s no standard qualification but lots of dedicated people in it,’ he said. Whatever their background, they needed to be competent, trained, supported and connected to local services, including police, bereavement and mental health services.

‘Like others, we’re being asked to do more for less,’ he said, and ‘very high regional variation’ meant there was even greater need for drug and alcohol services to be trained to work with families.

Adfam worked with decision-makers, practitioners and families and helped the three strands of activity to feed into each other.

‘There’s no gigantic evidence base on family support,’ he said. ‘But there’s something so affirming when families can meet someone in a similar situation who may be able to help.’

At the heart of effective outcomes were commissioners, and Fiona Hackland, strategic commissioner from the London Borough of Newham, shared her thoughts.

‘Commissioning is not just buying services, it’s a much more complex task,’ she said. ‘It’s about identifying what’s needed locally across services and making sure provision is in place to meet those needs.’

There was no qualification for commissioners, other than relevant components of DANOS. Local authority people were not used to commissioning health-based responsibilities and didn’t necessarily understand the process.

‘We can get bogged down in numbers and targets, but we need to focus on the differences we want to see,’ she said.

Funding was ‘clearly an issue’, with having to find savings from the public health grant, and the changing profile of substance misuse was an ongoing challenge. Reprocurement cycles were going to get worse, with short contracts causing ‘huge problems among service users’. Not viewing the commissioner-provider relationship as a partnership was also ‘not helpful’.

So how could commissioners ensure effectiveness?

‘Be clear about needs, prioritise needs and find the best way to meet those needs,’ she said. Specifying the service and outcomes we wanted was important – ‘without over-specifying, as that kills innovation’ – as well as taking service users’ views into account.

For those worried about the added pressures of CQC inspection since April, Patti Boden, CQC inspection manager, had words of encouragement.

‘I don’t go out looking for inadequate services – we go out looking for good,’ she said. ‘How open are they with commissioners? We’re trying to make sure services are well led, with clear vision and values and performance targets, KPIs and visible leadership.

‘We’re also looking to see that the recovery agenda is at the top of their list,’ she said, adding ‘this is not a tick list, but around evidence from service users.’

Among the elements for improvement were risk, care/recovery plans that were too generic, and the quality of commissioning and clinical interventions.

‘We tell you where you’re going wrong, but we don’t tell you how to fix it – that’s up to you,’ she said.

Taking stock of the day’s contributions, Carole Sharma asked ‘do we need to rethink the skills and knowledge of the effective practitioner?’

‘We’re facing an aging client population, multiple and complex needs, reduced generic services and a simplified view of what alcohol and drug problems are and how to fix them,’ she said.

It was more complicated than ‘just say no’ and a spell in rehab, with ‘entrenched problems’. Reduced budgets for training and development, reduced learning environments for some licensed practitioners such as doctors, large caseloads and the demands of the regulator were constant challenges – although the demands of the regulator were a step in the right direction ‘as they stop a lot of arguments about what is good’. But there were a lack of national drivers for workforce development and still no national qualification framework.

‘What are the questions we need to consider?’ she asked. ‘What’s the best use of trained specialists’ time and competence? Do we broaden our skills and knowledge to meet the emerging needs of clients and patients? Do we use our specialists to support the generic health and care workforce in relation to alcohol and other drugs? Has DANOS had its day?’

Appealing to the audience – and the profession as a whole – she added, ‘Is there a need for FDAP to change? If you do feel you need a professional organisation, a safe space to develop the workforce, you need to get people to join.’ **DDN**

What’s your view? Do you need the support of a professional organisation? Email responses to claire@cjwellings.com to contribute to our letters page, or send your questions for Carole Sharma on any aspect of workforce development.

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Rose Khatri – Tel 0151 231 4118 – Email r.j.khatri@ljmu.ac.uk

Read the full stories and more:
www.drinkanddrugsnews.com

What next for prison reform?

The recent Prisons Bill promised the biggest shake-up of prisons since the Victorian era (*DDN*, June, page 5). At a VolteFace event in London, journalist **Philippa Budgen** asked panelists: 'How can we have meaningful prison reform with drug policies that aren't working? What would be your messages for justice secretary Michael Gove?'

'SUPPLY DRUGS TO PRISONERS'

Prison reflects a crisis in society and over the last five years the situation has got worse. We don't control the supply of illicit drugs – they're in the hands of criminals. The only regulation is violence and coercion; there's no legitimacy to it. So if we want to address this we need to take the supply away from criminals.

Why don't we, as a pilot, supply drugs to prisoners who need them and see what happens? We have to make a start somewhere.

Eoin McLennan-Murray, retired governor of Coldingley Prison

'TAKE DRUGS OUT OF CRIME'

Organised crime groups in prison are the same groups outside, so debts can be enforced outside. People build up debts that can be collected in horrific ways, such as from their families. This sort of subversion shouldn't be allowed to happen, and the only way is to take drugs out of organised crime.

Less than 0.2 per cent of the population are committing 50 per cent of acquisitive crime. The reoffending rate for heroin users is 90 per cent. If the supply was taken away from organised crime, through prescribed heroin, you could cut crime overnight.

Neil Woods, former undercover drugs detective sergeant

'NO LARGE PRISONS'

Let's not follow the US system – large prisons are the foundation for organised crime and gangs. Small prisons done well can deter crime. Rehabilitation should not be about cramming people together in an impoverished environment.

David Skarbek, senior lecturer, King's College London

'REFORM SENTENCING'

The best way is to create healthy prison regimes. Drug reform and prison reform are only possible with sentencing reform – more people are going to prison for more things and for longer.

Andrew Nelson, director of campaigns at The Howard League for Penal Reform

'DON'T IMPRISON FOR POSSESSION'

Let's send fewer people to prison. People who'd never taken drugs start in prison – it has a toxic effect. Last year 7,000 people were sent to immediate custody for drug offences. Most were not big businessmen who make money out of drugs – these people are the minnows at the bottom of the chain.

We're in a mad situation – imprisoning anyone for possession can only make them worse.

Penelope Gibbs, director of Transform Justice

'TACKLE ESCALATING PROBLEM'

New psychoactive Substances (NPS) have changed everything – I saw the first consignments arrive. Now there are lots more prisoners using and running up more debts.

There won't be any change until it's treated as a medical and social challenge. Relying on prosecutions isn't going to work – the problem is escalating. We need to decriminalise personal possession and treat people as needing a psychological, medical and personal approach.

Alex Cavendish, former prisoner and reform campaigner

VolteFace is a policy innovation hub that explores alternatives to current public policies relating to drugs, www.volteface.me

MEDIA SAVVY

The news, and the skews, in the national media

THE PRINCIPAL EFFECT OF DRUG LAWS is to inflate the salaries of the nastiest barons and gangsters on earth, funding organised crime and corruption, and fuelling the self-immolation of whole nations, from Mexico to Albania and Afghanistan... But if enough people keep making forceful arguments based on the available evidence, the heresy of reformed drug laws will graduate not just to common sense but prevailing wisdom soon enough.

***Independent* editorial, 16 June**

IT MAY BE POLITIC not to rush discussion of full legalisation but that should still be the ultimate goal. In the long term it is not tenable to decriminalise possession of a substance while preserving the profit motive of the criminal gangs that supply it.

***Times* editorial, 16 June**

IT IS QUITE POSSIBLE that elements of the criminal underworld will shift their attention to other illegal activities once the narcotics gold mine is closed off to them, but legalisation would also free up enormous police resources to detect real crime. In any case, it is not the responsibility of government to provide lucrative openings for organised criminals.

Christopher Snowdon, *Telegraph*, 16 June

THE PRO-DRUG LOBBY likes to quote Portugal at us not because it wants Britain to copy what Portugal has done but because it counts on us not knowing what actually happens to drug users in Portugal and hopes that, like the *Times* headline did on Thursday, we will confuse the words 'decriminalised' with 'made legal'.

Ross Clark, *Spectator*, 18 June

IS ADDICTION A DISEASE? Most people think so. The idea has become entrenched in our news media, our treatment facilities, our courts and in the hearts and minds of addicts themselves... If it is, then we might expect it to have a specific cause or set of causes, an agreed-on repertoire of treatment strategies, and a likely time course. We might wonder how the disease of addiction could be overcome as a result of willpower, changing perspectives, changing environments, mindfulness or emotional growth. There is evidence that each of these factors can be crucial in beating addiction, yet none of them is likely to work on cancer, pneumonia, diabetes or malaria.

Marc Lewis, *Guardian*, 7 June

MORAL PANICS ARE NOT ALL BAD. Money will follow them. Show me a moral panic and I'll show you wads of cash. It happened with HIV and it happens with some illegal drugs. People get scared – maybe too scared – but things get done. It's just a matter of whether the right things get done.

Brigid Delaney, *Guardian*, 14 June

More harm reduction online at www.drinkanddrugsnews.com

SAFE SPACE

Wales is gearing up to offer medically supervised injecting centres – an initiative that can't happen soon enough, says **Ifor Glyn**

THERE IS A GROWING ACCEPTANCE AND EVIDENCE that providing safe and supervised injecting centres is a recognised harm reduction initiative that can lead to saving lives, encourage engagement with treatment services, and help reduce HIV and hepatitis C infections. They also address public concerns about discarded needles and public injecting, and do not attract drug users en masse from other areas.

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the first supervised drug consumption room was opened in Berne, Switzerland in June 1986, with further facilities following in Germany, the Netherlands, Spain, Norway, Luxembourg, Denmark and Greece. There are now 74 official drug consumption facilities operating in six EMCDDA reporting countries (following the closure of the only facility in Greece in 2014) and 12 facilities now operating in Switzerland.

The EMCDDA breaks this down further, to point out that as of February 2016 there are 31 facilities in 25 cities in the Netherlands; 24 in 15 cities in Germany; 12 in three cities in Spain; one in Norway; and one in Luxembourg (Norway and Luxembourg are both preparing to open a second facility in 2016); five in three cities in Denmark; and 12 in eight cities in Switzerland.

In January, French law approved a six-year trial of drug consumption rooms, expected to open by the end of this year. Outside Europe there are two facilities in Sydney, Australia and one medically supervised injecting centre in Vancouver, Canada.

There are plans to open the first centre in Dublin in later this year, and Scotland is also exploring the introduction of Medically Supervised Injecting Centre (MSIC). Even though there have been robust attempts to establish similar centres in the UK, there still no provision, despite the UK Home Affairs Select Committee recommendation 'that an evaluated pilot programme of safe injecting houses for heroin users is established without delay and that if this is successful, the programme is extended across the country.' The home secretary rejected this recommendation.

Wales is a country with a strong and unequivocal commitment to reducing the harm associated with substance misuse. The devolved Welsh government has harm reduction firmly embedded in its substance misuse strategy (Working together to reduce harm, 2008), which has led to a countrywide take-home naloxone scheme. It has also supported the set-up of Wedinos, a service to test substances to give individuals rapid and accurate information to reduce harms, and introduced and supported numerous harm reduction initiatives and projects. It is hoped that the Welsh government's delivery plan (2016-2018) will reference the need to develop a case for MSIC.

Drugaid Cymru, Wales's largest and leading third sector harm reduction agency, has started the work of developing the case for establishing MSIC provision in Wales. Not for a minute does anybody think this will be an easy task, and despite the evidence to support MSICs, winning the hearts and minds of politicians, law enforcement, businesses and neighbours is going to be a challenge. A multi-agency steering group has been established to progress this agenda in Wales, led by Drugaid Cymru, and includes leading figures from health, academia, PCC representatives, public health, Release and the Welsh Government.

Earlier this year, Drugaid Cymru's chief executive Caroline Phipps visited Sydney's Kings Cross centre and a deputation from Drugaid visited the Ana Liffey Drugs Project in Dublin who are close to opening Ireland's first MSIC. While there might be a need for different models for different communities, there are a lot of commonalities and much that can be learned from those who are established or moving toward being operational. Wales is forming partnerships with others to develop the business case and propose the right model.

> 'Winning the hearts and minds of politicians, law enforcement, businesses and neighbours is going to be a challenge.'

During the next six months the steering group will be engaging and consulting expert individuals and organisations in the UK and in other countries that have been involved in the research and development of MSIC provision. The work is at a very early stage in Wales and it is recognised that there are significant hurdles, but there is a commitment to develop a strong case for establishing MSIC as part of an overall comprehensive harm reduction approach – and to win over the hearts and minds of those with doubts.

Ifor Glyn will facilitate a workshop on MSICs at the upcoming conference SMTPC2016: 'The Post-War Dream'. To book your free place visit www.smtpc.org

DETOX IN A BOX

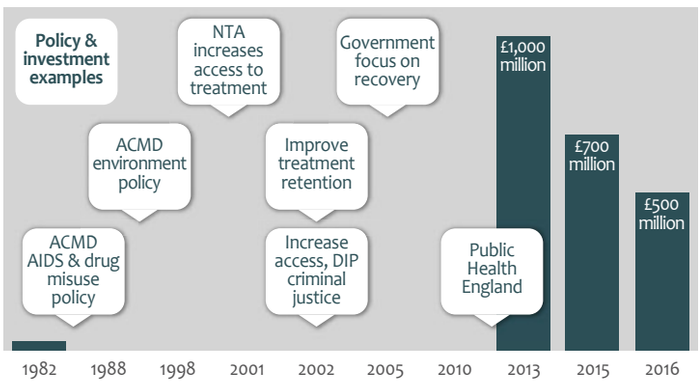
Encouraged by results of a new form of community opiate detoxification, a team from substance misuse services in Bristol and the South West offer their 'recipe for recovery'

The landscape for addiction treatment is changing. Since 2001, there have been three phases in the modernisation of treatment for substance misuse problems – access, retention, completion – that brought us to where we are now. We are now in an evolving fourth phase which is about producing real world recovery outcomes.

As a result of the Health and Social Care Act 2012, the public health function was transferred from the health service to the 152 local authorities. It is difficult to see where the investment in drug treatment is going with any precision but the direction is very clear; it is going down. Duncan Selbie, chief executive of Public Health England, addressed substance misuse commissioners and providers at a recent conference in Bristol entitled *Sustainable recovery solutions*. He highlighted the need to think and work smarter in these times of austerity: 'The music has changed – you need to learn a new dance!'

The rise and fall of investment in drug treatment

From £18m, 1982 to £1 billion in 30 years
Reductions of up to 50%



Spending on opioid & related dependence, UK

Source: applied strategic analysis NIGHTWATCHMAN database

Ironically, tightening budgets might be good news for abstinence-based community recovery. At the same conference, we noted that the current and evolving focus on real world social outcomes (such as jobs, homes, family and friends) offers great opportunities for the development of abstinence-based recovery and this reinforces a focus on innovation, improved outcomes and increased value.

As previous and current providers of substance misuse services in Bristol and the South West, we feel that our 'detox in a box' model demonstrates those very objectives – innovation, improved outcomes and increased value. However, not being the best of dancers, we prefer to liken it to cooking – our 'recipe for recovery'.

INNOVATION

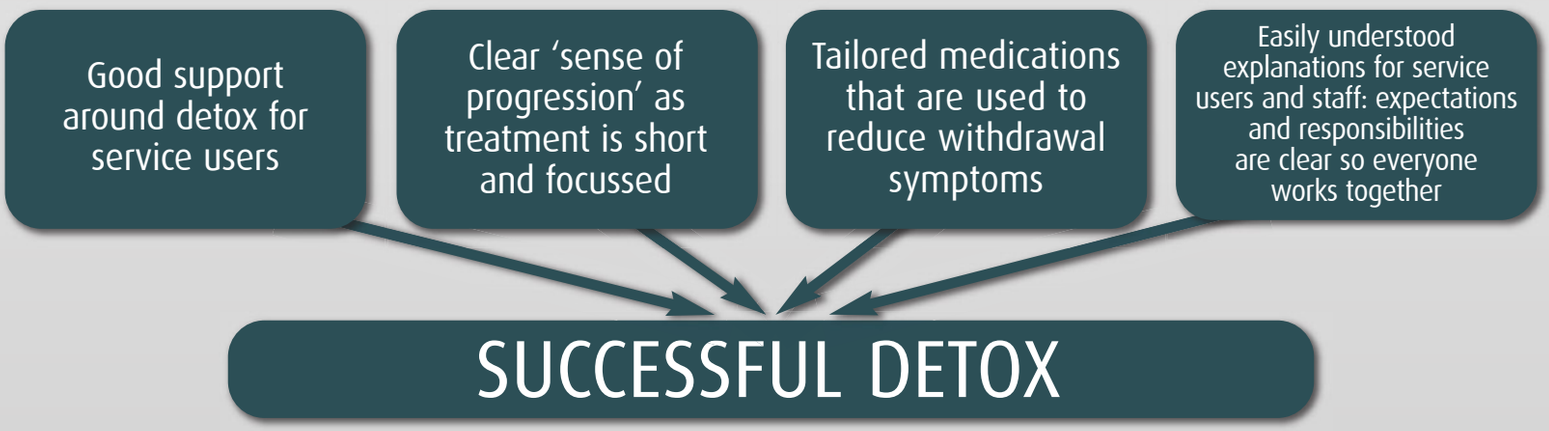
Back in 2010, South Gloucestershire Drug and Alcohol community services introduced a novel two-week community opiate detox protocol, which was created to address the problem of a long backlog of service users awaiting a structured opiate detox against a climate of limited bed availability for a medically supervised detox.

At this time, the practice was mainly focused on substitute prescribing and risk minimisation. The 'detox in a box' protocol brought a shift in mindset towards recovery and abstinence as well as higher aspirations for service user success, bringing hope back into the hearts of both clients and staff.

IMPROVED OUTCOMES

'Detox in a box' was rapidly embraced by both key workers and service users and proved highly successful over the subsequent four years, leading to a dramatic improvement in the number of service users exiting drug-free from our services. In the first year after its introduction, the number of patients achieving abstinence quadrupled. This dramatic improvement cleared the backlog of highly motivated clients waiting for a detox. Subsequent years showed a similar steady increase in the numbers of those achieving abstinence.

Unlike opiate detox methods involving gradual dose reduction, which may feel like an endless 'Russian doll' game (often ending up as long-term sub therapeutic OST prescribing), 'detox in a box' gave our service users a clear goal: the prospect of



'Detox in a box' The recipe at a glance

- Ability to reduce to <40mls methadone and transfer to buprenorphine
- Access to mutual aid support
- Only four outpatient visits needed over 14 days.
- Buprenorphine front-loading (days 1-3)
- Lofexidine (days 5-14)
- Naltrexone offered day 12 (but not compulsory)
- Clear aftercare plan in place

attaining abstinence in only 14 days. It also switched the client's focus from the detox process, to the real and more deserving challenge of maintaining abstinence and recovery.

INCREASED VALUE

Aside from the clear benefits of our clients having an improved chance of actually completing their detox, we found that running this model alongside the existing alcohol detox service made better use of resources – both in terms of facilities and staff. Having a programme that was time limited, with a clear beginning, middle and end, also enabled us to plan aftercare services more effectively. We also found that working alongside mutual aid groups such as SMART Recovery and NA was an essential ingredient in the success of the model. Using our existing relationships with our colleagues in community pharmacies helped to add another layer of support.

WHO IS IT FOR?

As with cooking, a dish only suits some people but not others. 'Detox in a box' best suits patients stabilised on methadone or buprenorphine, highly motivated to detox in the community within a short period of time and with no major psychiatric or physical health co-morbidities. It is unlikely to be successful for those still using heroin exclusively or on top of methadone.

CHALLENGES

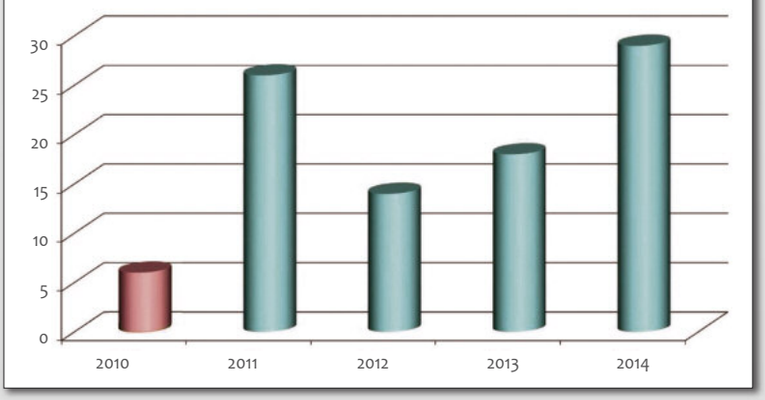
Before implementing this approach, we were disheartened by the number of service users who had been held on non-therapeutic doses of methadone and buprenorphine for long periods of time, because of fear or anxiety about the opiate withdrawal process. Their fears were further reinforced by a lack of confidence in staff around the medications that could be prescribed or the psychosocial advice that could be provided to help reduce the severity of the symptoms of opiate withdrawal. In addition, we were faced with new challenges which included an increased focus on treatment exits, compliance with our payment by results targets, a staff culture that focused singly on maintenance treatment, a service user expectation that engagement in psychosocial interventions was not required, and a general fear of change.

Our greatest challenge during the implementation stage was our ability to embed this approach as 'treatment as usual', alongside the slower reduction or 'Russian doll' approach that was more commonly used. Changing culture is often the hardest thing we do in healthcare services and staff engagement in the process was the key to ensuring the approach was owned by the service and offered to service users. To our surprise we achieved this very quickly. Peer mentors were involved from the start and their views adopted into the model; all staff members were trained, and awareness sessions delivered to partnership agencies. Leaflets were placed with all blank care plans, ready for discussion at the service users' next review appointment.

For us, it offered a fresh new treatment choice to add to the menu of options for our service users who were looking to make significant behaviour change and improve their lives.

About the authors:
R Iosub and I Seeger are senior registrars, South Gloucestershire and Bristol Specialised Drug and Alcohol Services, Avon and Wiltshire Mental Health Partnership NHS Trust. F D Law is consultant in substance misuse psychiatry at Turning Point. M Gilman is managing director of Discovering Health. N S Wallbank is team manager at Stokes Croft, Bristol Specialised Drug and Alcohol Services, Avon and Wiltshire Mental Health Partnership NHS Trust. J K Melichar is medical director, DHI; medical director, DMT Ltd and consultant in substance misuse psychiatry at Turning Point.

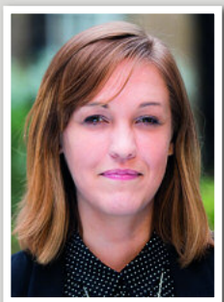
Number of patients exiting opiate-free from 'detox in a box' services



Outpatient opiate detox prescribing plan

DAY	1 Thurs	2 Fri	3 Sat	4 Sun	5 Mon	6 Tues	7 Weds	8 Thurs	9 Fri	10 Sat	11 Sun	12 Mon	13 Tues	14 Weds
Appointment (seen in clinic)	Seen				Seen		Seen					Seen		
Buprenorphine	**8mg (Split dose)**	**16mg**	**8mg**		*With our buprenorphine front-loading protocol patients have a milder, slower withdrawal that onsets on or after day 5 of detox (due to buprenorphine's long half-life and high occupancy). Therefore, no lofexidine is needed until day 5, and lower doses can be used with significantly reduced monitoring. Blood pressure only needs checking on day 5 – the patient has a baseline, takes lofexidine and blood pressure is rechecked 30 minutes later.*									
Lofexidine	qds: four times a day tds: three times a day bd: twice a day				**0.2mg qds**	**0.2-0.4mg qds, for days 6 to 11**						**0.2mg qds**	**0.2mg tds**	**0.2mg bd**

LEGAL EYE



Nicole Ridgwell of Ridouts answers your legal questions

What does 'treatment is a condition of the provision of the accommodation' mean? If treatment is provided but is voluntary and freely given, with no local authority/NHS involvement, and specifically excluded as a legal condition of residence in the tenancy/contract/licence, what then? Within scope or not?

NICOLE ANSWERS:

According to CQC's 'Scope of Registration', this phrase describes the regulated activity of providing residential accommodation together with treatment for substance misuse. The provider must provide 'accommodation' and 'treatment' and, significantly, the service user must utilise both at the same time. The provider may provide accommodation on a different site from treatment but, if linked, they are in scope. As CQC explains 'the accommodation is provided because someone requires and accepts treatment'.

The definition of 'treatment' within this regulated activity is wide-ranging, covering recognised interventions from managed withdrawal or detoxification to structured psychological programmes. In essence, if your form of treatment falls within the definition, and if to accept treatment a service user will be given accommodation, your service is within scope.

The question raises three conditional queries. Firstly, what if the treatment is 'voluntary and freely given'? I assume this refers to there being no cost to the service user. As readers will know, many programmes are free to service users, whether provided by charity or paid for by insurance. This would not alter whether the treatment is regulated for CQC purposes.

Next, where there is 'no local authority/ NHS involvement'. This is an interesting question. One interpretation is that the service does not take referrals from local authorities or the NHS. The simple response is that how service users arrive at the service does not change the nature of the regulated activity once there. Another interpretation is that the provider does not believe they are subject to local authority or NHS oversight. Whilst the latter can certainly be true, local authority safeguarding teams will always have some level of oversight and investigatory powers in relation to any provider providing regulated treatment in their vicinity.

The last condition is that treatment is 'specifically excluded as a legal condition of residence'. I am unsure whether this means that the service user's accommodation 'contract' purposefully omits a clause making treatment mandatory, or whether the provider is prohibited from providing treatment at the accommodation and must do so elsewhere. In either scenario, the answer is the same: if accommodation is provided because the service user requires and accepts treatment, it is within scope. No amount of clever drafting will change this.

If you fall within the definition you must be registered. It is vital that providers interrogate their systems and practices to check whether they are within scope. The consequences of finding out too late that you are without appropriate registration can be costly, financially and in terms of reputation; whilst the advantages of registration can include greater recognition, credibility and higher referral numbers.

Nicole Ridgwell is solicitor at Ridouts LLP, a practice of health and social care lawyers, www.ridout-law.com.

Send your legal queries to legal@drinkanddrugsnews.com

RECOVERY STREET FILM FESTIVAL

DOWN RECOVERY STREET

With just a few weeks left to enter the Recovery Street Film Festival, last year's winner **Ceri Walker** explains how she was inspired to make her film

I made my film, *Understanding Mum*, after seeing the festival promoted on Addaction's Facebook page. I have previously raised money for them, so thought this was another great way to support drug and alcohol charities.

I feel there's so much stigma attached to addiction. People feel that addicts should just stop, and it's their fault, but after many years of trying to understand my mum's behaviour I strongly believe it is a disease out of the person's control. I also didn't feel that people understood the impact being the child of an alcoholic had on the child, both at the time and as an adult, and after much support I really see a link between my behaviour now and my upbringing.

The part that was the most beneficial was how much it helped me work through my grief again, which was a surprise after so many years. But after I had my son it had really come to the surface again, as I struggled to see how my mum couldn't put me first.

Making the film was a bit of a rollercoaster ride. Some days I could spend hours on it and others I'd have to stop after ten minutes, as it became too intense to think about. It started off 20 minutes long, and it was difficult to prioritise which bits to keep in. My husband helped me with the editing and filming, which I hadn't got a clue about! But I tried to focus on the message I wanted to portray.

After winning the competition I got in touch with NACOA as I felt this charity would be great to support as its all about the families affected. I was really pleased they used my film for children of alcoholics week, and it was also shown in the House of Commons. I'm also pleased I can help by being on the judging panel of this year's Recovery Street Film Festival.

The Recovery Street Film Festival invites entries by 29 July from anyone who has experience of recovering from drug or alcohol addiction, whether themselves or a loved one. Prizes will be awarded for first, second and third place, with shortlisted entries shown at festivals throughout the UK. No experience of film-making necessary – visit

www.recoverystreetfilmfestival.co.uk

Gloucester House provides 12-step residential rehab for male clients from both statutory and private referrals. An historic 19th century townhouse in the market town of Highworth in Wiltshire, it has rooms on site for 13 clients and a local move-on house for three to four clients.

EMBRACING CHANGE

Managed by The Salvation Army, Gloucester House has been providing treatment for addiction for more than 50 years. Originally founded by a Salvation Army officer, who had been an alcoholic himself when he was in the Merchant Navy, it was a dry house that provided help and a home for men of the road with alcoholic problems.

As its Mission states:
At Gloucester House we are passionate about igniting the unique potential of every individual.

We aim to inspire clients to embrace ongoing change, to build a new life free from addiction.

We do this by providing a safe, supported environment, which is inclusive, structured and fair. We offer an holistic programme which addresses the physical, mental, emotional and spiritual wellbeing of each individual.

We have a professional, qualified and trained team, with good boundaries and good ethical practice.

The GH step journey is a bespoke programme...
A core principle of the centre is building community and promoting independence. Strength is derived from relationships that re-enforce unity, a sense of belonging and peer support. Clients are motivated to develop resilience, resources and life skills through our holistic programme.

Clients come from agencies all over the country, from diverse backgrounds, faiths and cultures. The programme is spiritual but not religious, and all views are respected.

'We aim to inspire clients to embrace ongoing change, and to build a new life free from addiction.'

ROS ROLFE
(Programme Coordinator)

Alongside the 12-step programme, an integral part of the holistic treatment is provided by occupational therapy, through craft workshops, gardening projects and other practical skills – alongside classroom-based learning in IT and basic maths and English, for those who need it. This essential part of the process allows clients to build self-esteem and improve their personal and social capital.

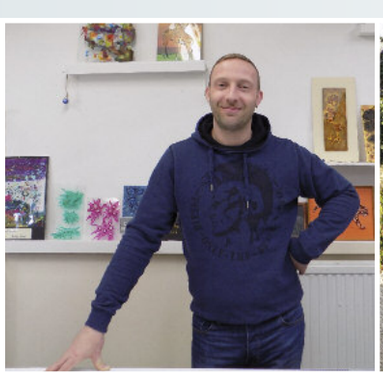
Following their initial treatment, clients are supported through Stage 2, which provides opportunities to consolidate their recovery in the wider community. This is achieved via voluntary work placements or training courses and allows clients to demonstrate greater responsibility and independence.

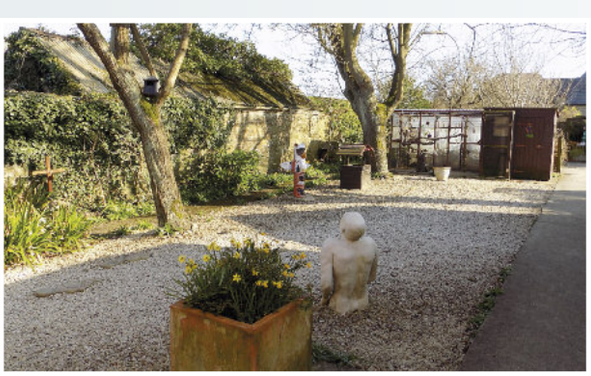
All clients leaving Gloucester House are offered resettlement, if not returning to their own home. This would be in one of several, abstinence-based, supported move-on houses that we work with, or locally in our third-stage accommodation.

Former residents that are resettled locally can return for aftercare support groups, and are encouraged to offer peer support to new clients.

Gloucester House is a beautiful, tranquil place where clients do experience life-changing transformation, by embracing recovery and finding freedom from addiction.

www.gloucesterhouse.org.uk





Willowdene meant for life rehabilitation

Willowdene Rehabilitation, a leader in the field of residential and day care services, supports both men and women with substance misuse and/or offending backgrounds through interventions to enable lifestyle transformation.

Through Willowdene's continued success in the sector, our ongoing expansion requires the recruitment of both full and part-time permanent roles, in the following areas:

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Evening and weekend support staff
Support staff/trainer

We are looking for people with a passion to work within this sector, and although experience in a Rehabilitation or Criminal Justice setting is an advantage, full training will be provided. Accommodation available.

For further information and full job descriptions please email sarahlou@willowdenefarm.org.uk

Closing date for all applications is 12 noon on July 25th

In recovery?

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RAPt Apprenticeship Scheme

We are offering a one year contract paying £15,300 per year (plus regional allowance), twenty-five days holiday, on-going training, and funding for a counselling course. You must be over nineteen years old, in abstinent recovery for two years, and with at least five years since your last criminal conviction.

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We particularly need apprentices in Brighton, Surrey, Kent, Hull and Norfolk.
For more information see our website, or contact:
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E: nathan.motherwell@rapt.org.uk
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MANCHESTER CITY COUNCIL

Manchester City Council – on behalf of GM Authorities

ALCOHOL & DRUG IN-PATIENT DETOXIFICATION AND RESIDENTIAL REHABILITATION SERVICES – SOFT MARKET TESTING EVENT

Friday 30 September 2016, 9.30 am – 12.30 pm
Friends' Meeting House, 6 Mount Street, Manchester, M2 5NS

On behalf of Greater Manchester Authorities, Manchester City Council intends to tender for a Framework Agreement for alcohol & drug in-patient detoxification and residential rehabilitation services. We welcome attendance from organisations that provide these services or who may be interested in providing these services.

The aim of the event is to:

- *Share the strategic direction for alcohol & drug services in Greater Manchester*
- *Share information and engage with service providers on the service model and service specifications*
- *Provide information on the proposed procurement process and timetable*

Attendance at the event will not confer any advantage to any potential bidders nor will your organisation be disadvantaged by not attending the event.

Places will be limited to two per organisation.
If you would like to book a place, please send your name, name of organisation, number of places and email address to: r.taylor2@manchester.gov.uk or telephone 0161 219 6922.

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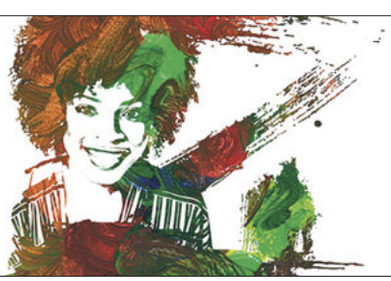

"I was wishing my life away at work. Now I'm helping people rediscover theirs."

At Turning Point, we support people across England with substance misuse issues. As a part of our clinical team, you'll make a real difference to their lives as you go above and beyond to help them with their daily needs. Passionate about people, you'll enjoy the scope and support to enhance your own life and career too, as you gain the experience and training you need to progress in your clinical career.

We have a range of opportunities available including Recovery Nurse, Speciality Doctor and Independent Non-Medical Prescriber.

You will be involved in a range of activities to help us provide the best possible experience to those who come to us for treatment and support. You will ensure our services are never short of the highest quality and all the way through, you'll have access to outstanding training and career development resources.

As a part of the team, you'll have a real desire to work in the substance misuse sector, together with a good understanding of clinical governance and the recovery agenda. Ideally, you'd have already worked in a similar setting. And of course, we're looking for individuals who love talking to people with different needs, and possesses a deep level of empathy, understanding and patience.

Running services on a not-for-profit basis, we invest every penny back into our services and our people.

So, if you're ambitious and focused on helping people with substance misuse issues, progress your career with us.

All current opportunities can be found on our careers website: https://careers.turning-point.co.uk/

You can also contact: Carla.Gorman@turning-point.co.uk

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