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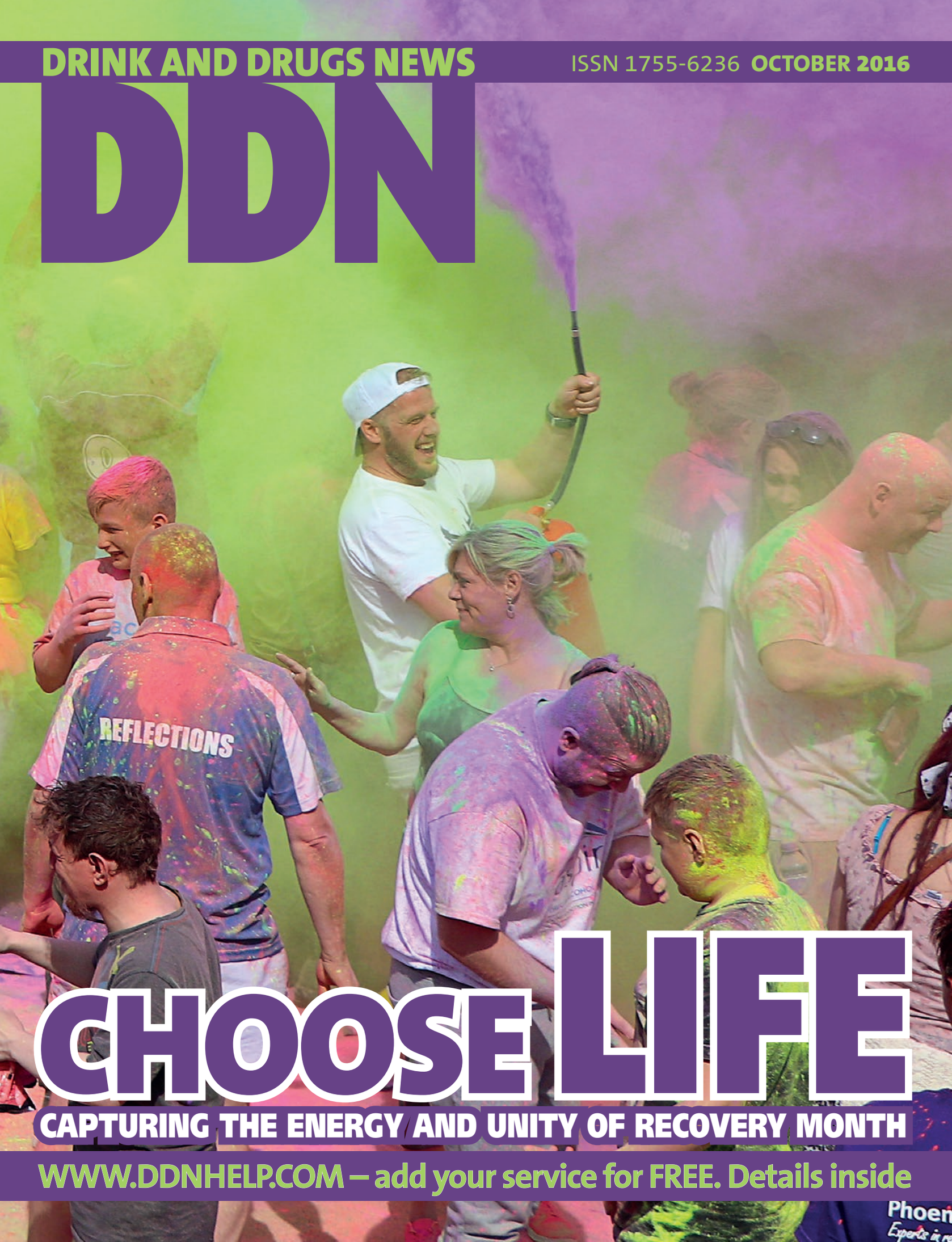

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ON THE COVER

Service users come together for Recovery Month and Overdose Awareness day. Pic by RDaSH Communications.

EDITOR'S LETTER

'Forget shouting... where would we be without the everyday heroes who just get on with things?'

It's easy to take notice of those who shout the loudest, but where would we be without the everyday heroes who just get on with things? The article about Pat Lamdin's retirement (page 16) is not just an appreciation of a jolly good bloke – the piece is bursting with frustration at the sector's failure to cherish and retain good people. Pat stayed in his job because he had a meaningful connection with the clients he was working with and cared more for them than for personal career progression. His ambitions were for their welfare over 'advancing' to management. But there are countless tales of other talented people who have left the sector because their job no longer feels like a vocation.

What's your experience? Maybe you love your job and are following your chosen career path like Hannah Feeney, page 18. Are you working within a supportive structure that makes you feel motivated, or are you feeling demoralised by targets and budget constraints, and looking for a way out? Let us know – in confidence if you prefer. Help us identify what the workforce needs and what makes you come to work each day.

Also in this issue – including our joyous cover picture! – we celebrate Recovery Month (page 6), take the opportunity to look at the origins of the term 'recovery' (page 12), and note that in commemorating Recovery Month and International Overdose Awareness Day, communities are sharing the same goals, campaigns and, in many cases, members – demonstrating a unity of purpose that defies being categorised as belonging to one 'movement' or another.

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www.drinkanddrugsnews.com

HEROIN DEATHS DOUBLE IN JUST FOUR YEARS

THE NUMBER OF HEROIN-RELATED DEATHS in England and Wales has doubled since 2012, from 579 to 1,201, according to the latest ONS figures. Last year saw the highest number of drug-related fatalities ever recorded with 3,674 poisoning deaths, of which 2,479 exclusively involved illegal drugs. Scotland also recorded its highest drug death toll in 2015, at 706 (*DDN*, September, page 4).

Although the government is keen to stress that the figures come against a background of falling rates of overall drug use, deaths involving cocaine also reached an all time high at 320 – up from 247 the previous year. Deaths involving amphetamine also reached their highest-ever level, and those involving ecstasy the highest in more than a decade.

Overall most drug deaths were again among the over-30s, with the North East of England the region recording the highest number of deaths for the third year running and males almost three times more likely to die than females. Although, as in Scotland, the number of deaths involving NPS remained relatively small, the substances could 'present a more significant problem in the future, especially as not enough is known about the long term effects of their use', stressed Public Health England (PHE).

An independent expert group convened by PHE and the Local Government Association (LGA) has published a list of recommendations to try to address the rising death rate, including improving access to treatment – especially for 'harder to reach' populations through outreach work and needle and syringe programmes – and coordinating a 'whole-system approach' that includes mental health, housing and employment support.

'Drug use is the fourth most common cause of death for those aged 15 to 49 in England...'

ROSANNA O'CONNOR

'Drug use is the fourth most common cause of death for those aged 15 to 49 in England and we know that the majority of those dying from opiates have either never, or not recently, been in treatment,' said PHE's director of drugs, alcohol and tobacco, Rosanna O'Connor. 'Reassuringly, overall drug use has declined and treatment services have helped many people to recover but there is a need for an enhanced effort to ensure the most vulnerable can access treatment.

There is considerable variation across the country, with some regions showing large increases in recent years. PHE will continue to support local authorities in delivering tailored, effective services where people stand the best chance of recovery.'

The 'shocking' statistics raised serious concerns about both government policy and the state of the treatment sector, however, said Release executive director Niamh Eastwood. 'Since 2010 we have seen a worrying implementation of abstinence-based treatment under the government's ideologically-driven "recovery" agenda. This goes against all the evidence for best practice in drug treatment, and is contributing, we believe, to this shameful rise in deaths. Such a hostile environment means people simply don't want to access treatment.'

There was also 'an increasing tendency among local authorities to simply offer treatment contracts to providers who can deliver the service for the lowest cost,' she continued, with healthcare standards 'being overlooked' for financial reasons. 'The Home Office's pursuit of a "tough on drugs" strategy and refusal to acknowledge the evidence for best practice in drug treatment is quite literally killing people.'

Deaths related to drug poisoning in England and Wales: 2015 registrations at www.ons.gov.uk

Understanding and preventing drug-related deaths: The report of a national expert working group to investigate drug-related deaths in England at www.nta.nhs.uk

HEP OPTIMISM

ANOTHER 'POTENTIAL CURATIVE' DRUG for people with hepatitis C is to be made available on the NHS, according to new guidance published by NICE. Elbasvir/grazoprevir has shown cure rates above 90 per cent in some patient groups, says the document, and 'provides considerable health benefits to patients without some of the adverse side effects associated with earlier anti-viral treatments', according to director of NICE's centre for health technology evaluation, Professor Carole Longson.

MENTOR MERGER

TWO LEADING DRUGS EDUCATION CHARITIES are merging this month. Mentor UK, known for its work preventing alcohol and drug misuse among children and young people will join with Angelus, the only UK charity dedicated to highlighting risks from new psychoactive substances. The organisation will be called Mentor UK, with Michael O'Toole as chief executive. 'This merger is a great match of expertise – it is going to give fresh impetus to the prevention agenda,' he said.

STAND AND DELIVER

A THREE-YEAR SUBSTANCE MISUSE DELIVERY PLAN has been launched by the Welsh Government, including better collaboration between mental health and substance services and more work to reduce blood-borne virus transmission. 'We want to ensure everyone can access the support and information that they need,' said minister for social services and public health, Rebecca Evans. The country has also seen a 14 per cent increase in the distribution of take-home naloxone kits, according to figures from Public Health Wales. The kits were reportedly used in more than 430 poisoning events in 2015-16. *Substance misuse delivery plan 2016-2018 at gov.wales; Take home naloxone 2015-16 at www2.nphs.wales.nhs.uk*

QUITTING TIME

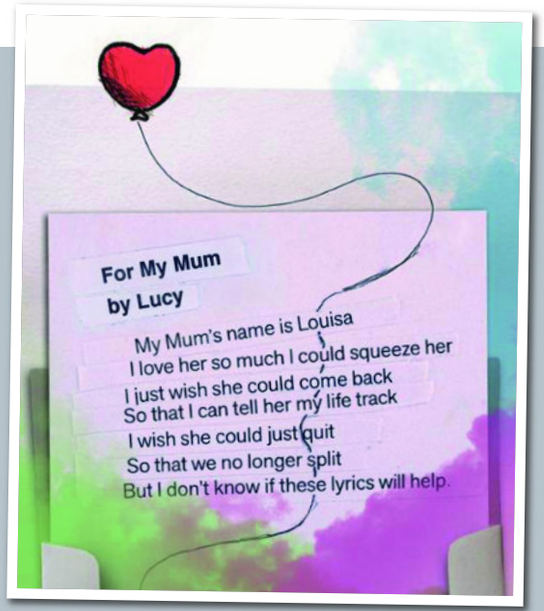
THE SMOKING RATE IN ENGLAND HAS FALLEN to its lowest ever level, at below 17 per cent, according to figures from PHE. Last year saw 500,000 smokers successfully give up, with cigarette sales in England and Wales dropping by 20 per cent in just two years. 'There is more help and support available now than ever before,' said deputy chief medical officer Dr Gina Radford. 'The introduction of standardised packs removes the glamorous branding and brings health warnings to the fore, and e-cigarettes, which many smokers find helpful for quitting, are now regulated to assure their safety and quality.'

Cigarette sales in England and Wales have dropped by 20 per cent in just two years.

PRISON PAUSE

JUSTICE SECRETARY LIZ TRUSS (pictured) has raised doubts about whether the wide-ranging prison reforms set out in the Queen's Speech (*DDN*, June, pages 5 and 7; September, page 10) will now go ahead, telling a meeting of the justice committee last month that, 'I am not committing to any specific piece of legislation at this stage'. Meanwhile, a report by the Prison and Probation Ombudsman has said there is 'an unacceptable level of violence' in English and Welsh prisons. Establishments should have a coordinated approach to identifying risks of bullying and violence, it says, including 'the impact of new psychoactive substances and associated debt'.

Learning lessons bulletin at www.ppo.gov.uk



FAMILY FAVOURITES

ADFAM'S ANNUAL FAMILY VOICES COMPETITION is now open, with a top prize of £150 and two runner up awards of £100. Friends and family who have lived through someone else's substance misuse are invited to submit an original piece of writing or poem, with the winning entries read by a guest speaker at the charity's carol concert on 1 December. 'While it is often difficult to talk about this subject, it can be helpful to write about it, and entries are of a consistently high standard,' says Adfam. Send your entry (up to 500 words) to carols@adfam.org.uk by 31 October.

OVERDOSE ACTION

CGL has issued more than 6,000 naloxone kits and successfully trained 5,500 service users, carers, family members and others in how to use them since February this year, the charity has announced. CGL is currently the only commissioned drug service in the UK to have a national approach to distributing the overdose-reversing substance.

'Our commitment to distributing naloxone as widely as possible and to training people on how to use it correctly has resulted in 241 lives being saved,' said CGL's director of nursing and clinical practice, Stacey Smith. 'We are committed to reducing drug-related deaths and naloxone plays a major role as part of an overall preventative package of care.' *See feature, next issue.*

'Our commitment to distributing naloxone as widely as possible and to training people on how to use it correctly has resulted in 241 lives being saved'
STACEY SMITH

MEDICINAL MESSAGE

A report calling for medicinal cannabis to be legalised has been issued by the All Party Parliamentary Group for Drug Policy Reform. *Cannabis: the evidence for medical use* is based on a seven-month inquiry, testaments from more than 600 patients and a review of international evidence. 'Many hundreds of thousands of people in the UK are already taking cannabis for primarily medical reasons,' said the group's co-chair, Caroline Lucas MP. 'It is totally unacceptable that they should face the added stress of having to break the law to access their medicine.' *Report at www.drugpolicyreform.net*

MAMBA BAN

The European Commission is proposing an EU-wide ban on MDMB-CHMICA, also known as Black Mamba. Nearly 30 deaths have been recorded in eight member states, says EMCDDA, with the substance – already banned in the UK under the Psychoactive Substances Act – also linked to incidences of violence and aggression.

GROWING MARKET

Bodybuilders are increasingly turning to dealing steroids to fund their own use and 'maintain their social status in the weightlifting community', according to a report from Birmingham University. 'While many government agencies and sport officials have suggested that substances are sold largely by organised crime groups for financial gain, the findings showed that the majority of performance and image enhancing drugs within bodybuilding subcultures were distributed by individuals for social reasons or to support their own training,' it says. *Social suppliers available at www.bcu.ac.uk*

WIDER IMPACT

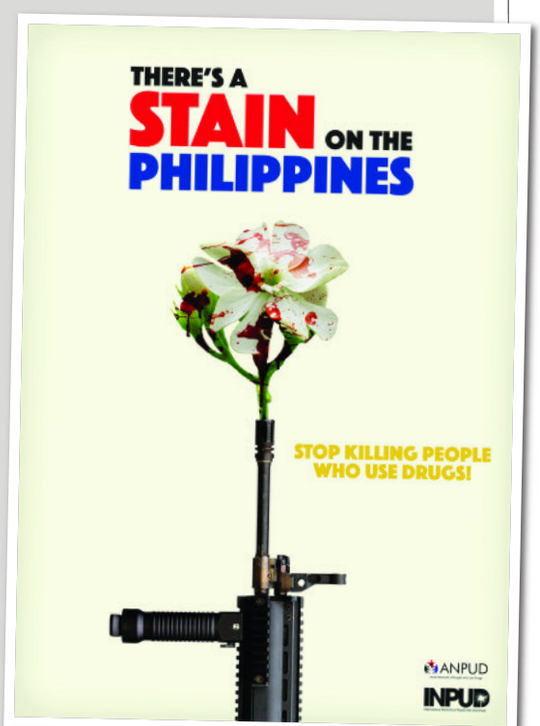
More than half of Welsh adults have had negative experiences in the last year as a result of someone else's drinking, according to a report from Public Health Wales. Almost one in five had felt physically threatened, while 5 per cent had suffered actual physical violence and the same percentage had been concerned about a child's wellbeing. 'This report shows how alcohol can harm not just the drinker but also those around them,' said the agency's director of policy, research, and international development, Professor Mark Bellis. 'Some of these harms are due to drunken violence but others result from accidents, threats or even financial problems when too much household income goes on one person's drinking.' *Alcohol's harm to others at www.wales.nhs.uk*

STRATEGIC SUPPORT

A new support pack for commissioning specialist interventions for young people experiencing substance problems has been issued by PHE. 'Patterns of drug and alcohol use by young people often change, which means that services need to be flexible and respond effectively to changing needs,' says *Young people – substance misuse JSNA support pack 2017-18. Available at www.nta.nhs.uk/uploads/jsna-support-pack-prompts-young-people-2017-final.pdf*

TIME TO GET INVOLVED: A 'global campaign week' against the actions of Philippines president Rodrigo Duterte is being organised by The Asian Network of People who Use Drugs (ANPUD) and the International Network of People who Use Drugs (INPUD). Peaceful demonstrations will begin at Filipino embassies and consulates around the world from Monday 10 October, and people are also encouraged to help raise awareness on social media. More 3,000 people are estimated to have fallen victim to Duterte's 'war on drugs' since he took office in May (*DDN*, September, page 4).

Full details of how to take part at www.inpud.net. See news focus, page 8.



RECOVERY MONTH...OVERDOSE AWARENESS..

CHOOSE LIFE

The stakes have never been higher. This year's Recovery Month and Overdose Awareness Day activities brought service users and recovery communities together with one clear goal

'GET POLITICAL': THE RECOVERY WALK

DURING THE LAST 12 MONTHS WE HAVE SEEN UNPRECEDENTED LEVELS OF DISINVESTMENT IN TREATMENT and recovery support services and the highest levels of drug-related deaths ever recorded. Despite this, during this September's Recovery Month, we celebrated the gains made by those in recovery, just as we celebrate improvements made by those who are managing other health conditions.

Taking part in September's Recovery Month reinforces the positive message that behavioural health is essential to overall health; that prevention works, treatment is effective, and people can and do recover. More people than ever before across the UK organised local events, celebrating the fact that recovery from addiction to alcohol and other drugs is a lived reality in their lives and that demand for our advocacy and training services has continued to grow.

As austerity continues it is becoming apparent that the state can no longer guarantee effective, high quality treatment for all and we are hearing of funding cuts to services in England of up to 40 per cent. There has never been a more important time for recovery communities to stand up, speak out and become politically engaged. We need to highlight the fact that every day in the UK people in long-term recovery from addiction to alcohol and other drugs volunteer their time to help others and make their communities better places to live. They are truly one of the greatest assets local communities have.

We received significantly less sponsorship funding for the UK Recovery Walk than in previous years and yet it was the biggest and best so far, with more than 6,000 people in long-term recovery and their friends and families. A special thank you to all of this year's sponsors and our amazing team of more than 300 volunteers who enabled us to be custodians of the famous UK Recovery Walk. We look forward to seeing you next year in Blackpool!

Annemarie Ward, Faces and Voices of Recovery UK. View FAVOR UK's short film challenging negative stereotypes and stigma at www.facesandvoicesofrecoveryuk.org

'LET'S CONNECT': RECOVERY COMMUNITY

THE FIFTH ANNUAL LUFSTOCK EVENT TOOK PLACE FOR THREE DAYS, bringing families of the recovery community together for a camping weekend. The 250 people who attended connected as a community, creating strong friendships and lasting memories.

This followed Lancashire User Forum (LUF)'s ten-year anniversary event in Preston, attended by service users, volunteers, treatment providers, and other interested parties. It was broadcast live by BBC Radio Lancashire's Sally Naden and Brett Davison, but the format of this special occasion was devised by the service users. As part of a packed agenda, we hosted the spoken word artist, Steve Duncan, who composed a unique poetry performance especially for our anniversary.

Not only was the event a resounding success; it also provided an open forum where professionals were scrutinised in regard to the landscape of the LUF over the next ten years. It built on the notion of hearing the service user's voice and having a positive impact on all recovery communities.

Meloney Hafeji, Red Rose Recovery

'TEAM SPIRIT': RECOVERY GAMES

MORE THAN 400 PEOPLE FROM ALL OVER YORKSHIRE AND LANCASHIRE came to celebrate being drug and alcohol free at the third annual Recovery Games – an initiative from Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and The Alcohol and Drug Service (ADS), under the newly launched partnership of Aspire.

The games link to the five ways to wellbeing and offer an exciting platform for people in treatment and recovery and those working with them to have fun and build on the principles of connecting with each other in new ways without substances. They offer a chance to learn new skills and ways of communication, while giving time, effort and money to worthwhile causes.

They show what recovery can feel like and create momentum through forming a giant conga through the 'festival of colour'. And most of all they show that there's nothing better than being active, getting out and about, and feeling alive, when you've been stuck in a rut like *Groundhog Day*.

The day had a strong family theme, supporting

.RECOVERY MONTH...OVERDOSE AWARENESS...

Read the reports, see the pictures: www.drinkanddrugsnews.com

> 'As austerity continues... the state can no longer guarantee effective, high quality treatment for all and we are hearing of funding cuts to services in England of up to 40 per cent. There has never been a more important time for recovery communities to stand up, speak out and become politically engaged. '

Pics: Recovery Games by RDaSH communications; Recovery Walk by Ade Barnett.

active recovery in community and family structures. Health professionals from across services came to deliver information on cancer awareness, smoking cessation and healthier eating, as well as offering prizes. There were activities for the children – although everyone let their inner child play out on the day!

Competitors took part in canoeing, climbing and many other events on giant inflatable arenas at the local activity centre. Teams of ten from all parts of Yorkshire and Lancashire entered events throughout the day, creating a spirit of competition combined with support. The weather was fantastic, which drew in the local crowds to cheer everyone on. There was music and live entertainment throughout, with an amazing festival of colour at midday, involving all the teams.

Money from the day was raised for the Aurora cancer charity and presented to them at the New Beginnings open day and graduation on 28 September.

Stuart Green and Neil Firbank, Aspire, www.aspire.community

'NALOXONE SAVES LIVES': OD AWARENESS DAY

DRUG FATALITIES HAVE OVERTAKEN FATALITIES DUE TO ROAD ACCIDENTS FOR THE FIRST TIME, representing a public health issue of growing proportions. In response to this, and to International Overdose Awareness Day on 31 August, we held three events in Greater Manchester, with a particular focus on raising awareness that naloxone saves lives.

An awareness event in HMP Manchester saw 25 inmates with a history of opioid use take part in animated discussions. All participants signed up for training on naloxone and will as a result receive kits on leaving prison. This generated much discussion among prisoners, wardens and other prison staff, with the goal of normalising overdose prevention as part of the prison's regime.

A mixture of commissioners, service providers and frontline workers attended a similar event chaired by Hayden Duncan of Emerging Futures. Hayden recalled the successful deployment of naloxone across the West Midlands during his time as Public Health England regional manager, and challenged the North West, 'the home of harm reduction', to step up and take action in relation to drug-related deaths.

Finally, a public awareness event was held in the centre of Manchester. Undeterred by lashing rain, members of the Greater Manchester Recovery Federation (GMRF), and other activists, collapsed in the street and came back to life to reveal 'Naloxone Saves Lives' t-shirts – simple but effective, generating a great deal of interest, and basic information on naloxone was also distributed.

All good – but what emerged at every event was just how little awareness there is, not just about naloxone, but overdose prevention itself. Even those who have experienced one or multiple overdoses lack the basic knowledge to prevent drug-related deaths. Perhaps even more shocking, many of the actions people would take in overdose situations could actually make matters worse.

Despite legislation designed to widen the availability of naloxone, its distribution is patchy. Many treatment services are stepping up to the mark, but most overdoses occur among populations who are not currently engaged in treatment. Many people lacked a basic understanding of what naloxone is and what it does; however, offsetting this was the sheer willingness of people to learn about, be trained in and carry naloxone.

Perceived divisions between those who support a harm reduction or a recovery approach should not get in the way of this. These divisions are largely political and do not represent the view of recovery communities who, as part of their own health and wellbeing, have a desire to support people in any way they can.

Resources are tight, those outside treatment services may be seen as harder to reach and there are many competing issues around the health agenda. However, we have recovery champions, peer mentors or volunteers in every treatment service, many active recovery communities around the country and staff within services more than willing to go the extra mile. Why are we not mobilising this huge resource?

The events in Greater Manchester were a success on many levels – awareness was raised, myths were busted and people were engaged. A Greater Manchester Naloxone Action Group was born and will push the agenda forward. However, to make a dent in the figures we need to see a more proactive approach nationally, and people could do worse than look to the West Midlands for how to do this.

Michaela Jones, in2recovery; and the Greater Manchester Recovery Forum

For the stories behind the news
www.drinkanddrugsnews.com

PUNISHING REGIME

The president of the Philippines, Rodrigo Duterte, has been taking the 'war on drugs' to extremes that have shocked the world. *DDN* asks what, if anything, the international community can do to stop the man known as 'the punisher'

When Rodrigo Duterte was elected president of the Philippines in May and vowed to 'eradicate crime' in the country within six months, those who voted for him may have had some idea of his likely approach.

His long stint as mayor of Davao City in the south of the country saw human rights groups accuse him of tolerating or even supporting the extra-judicial killings of offenders, and he stated on the campaign trail that he intended to 'fatten the fishes' in Manila Bay on the bodies of dead criminals. Unsurprisingly, his short presidency has so far been characterised by astonishing brutality.

More than 3,000 people – mainly drug dealers and drug users – are estimated to have fallen victim to Duterte's 'war on drugs', and while just over a third of these are thought to have been killed by police, human rights observers believe the others could be the victims of the president's open call for vigilante action against those suspected of drugs offences. Known as 'Duterte Harry' and 'the punisher', Duterte has now asked his people for a six-month extension to fulfil his crime reduction pledge, as he 'cannot kill them all'.

While the killings have inevitably provoked international outrage it has so far been met with defiance. Duterte has threatened to pull his country out of the UN, while seeking closer economic ties with China and Russia, and his response to US criticism of his actions was to call Barack Obama a 'son of a whore'. As he also continues to enjoy very high approval ratings among his electorate, it's hard to see what can be done to end the violence.

In August an open letter signed by more than 300 NGOs implored the UN's drug control bodies to call for an 'immediate stop' to the killings. The United Nations Office on Drugs and Crime (UNODC) executive director Yury Fedotov said that his agency was 'greatly concerned' by the reports of extrajudicial killings and that he joined the UN secretary general's condemnation of the 'apparent endorsement' of them (*DDN*, September, page 4). While the UNODC stood 'ready to further engage with the Philippines... to bring drug traffickers to justice with the appropriate legal safeguards in line with international standards and norms,' he said, the killings contravened 'the provisions of the international drug control conventions' and did not 'serve the cause of justice'.

ZUMA Press, Inc. / Alamy Stock Photo

As Duterte continues to enjoy very high approval ratings among his electorate, it's hard to see what can be done to end the violence.

Given the circumstances, however, did that go far enough? 'The UNODC statement could have been more strongly worded,' Bangkok-based senior policy officer for the International Drug Policy Consortium (IDPC), Gloria Lai, tells *DDN*. 'The statement by the INCB [International Narcotics Control Board] was stronger in that president Werner Sipp called on the Philippines government to "issue an immediate and unequivocal condemnation and denunciation of extrajudicial actions against individuals suspected of involvement in the illicit drug trade or of drug use, to put an immediate stop to such actions, and to ensure that the perpetrators of such acts are brought to justice in full observance of due process and the rule of law."'

Statements by UN special rapporteurs on the right to health and on extrajudicial, summary or arbitrary executions have also been strong, she points out, but there's more that international drug control bodies could be doing.

'Policy makers and officials in the Philippines – ranging from the police to the judiciary to health officials to political representatives in the congress and senate – might welcome technical assistance in developing and implementing evidence-based and humane drug policy responses,' she says. This help could cover the health and welfare of detainees in 'horrifically overcrowded prisons', the more than 700,000 people who have surrendered themselves to the authorities 'mostly for using or having used drugs, or simply being arbitrarily placed on a published list of so-called drug suspects', as well as provision of drug treatment and harm reduction services. It could also address some 'alarming legislative proposals' including one to re-instate the death penalty, abolished a decade ago, and another to lower the age of criminal responsibility from 15 to nine.

Agencies such as UNAIDS and the World Health Organization (WHO) could also offer advice and guidance on drug policy issues, she continues, particularly in terms of contributing evidence to policy debates in the Philippines that helps to counter 'baseless and false claims' about the extent of the country's drug-related problems 'made by the president and other officials'. Among these are that people who use shabu (crystal meth) 'suffer from brain shrinkage and become no longer human', she points out. The UNODC could also extend its practical assistance, as it has done with Myanmar, she adds.

In the meantime, however, the killing is showing no sign of letting up, and with Duterte asking for his six-month extension to 'finish the job', what, realistically, could other countries be doing to address the situation?

'They could try to boost incentives for shifting this approach, for example by raising concerns and supporting alternative humane and effective approaches in UN drug policy and human rights forums,' she states. 'But one perspective is that Duterte has continued to incite murder because it has served him well in gaining popular support and winning the presidential election, so he has little incentive to change this approach.'

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

POST-ITS FROM PRACTICE

HEALING THE HURT

Taking painkillers can mask issues that are nothing to do with physical pain, says Dr Steve Brinksman

'...bouts of low mood and panic attacks had eased since starting her painkillers.'

LIKE MANY MODERN GP GROUP PRACTICES, ours has GPs with specialist interests. One of mine is rheumatology and it was in this role that I met Maria. She was 43 and had been diagnosed with rheumatoid arthritis four years ago. She had a lot of joint pain and was started on co-codamol 30/500 (30mg codeine and 500mg paracetamol in each tablet) She was taking these regularly, so slow release dihydrocodeine was added in and titrated up to 120mg twice a day with Oramorph (liquid morphine) for breakthrough pain.

After seeing a consultant rheumatologist she was started on methotrexate, a disease modifying anti rheumatoid drug (DMARD), and was being seen in our clinic so that this could be monitored.

On examination I could find no signs of active joint inflammation and noted this had been the same the last couple of times she had been seen. When the possibility of reducing her analgesia had been suggested before, she said she still needed it. When I asked her about this, she told me that she felt much better in herself when she took her medication and worried that she would be 'bad' if she didn't. She explained that she had previously had bouts of low mood and panic attacks, which had eased since starting her painkillers, and that the Oramorph was now mainly used when she was anxious.

There wasn't time to explore this further, but she agreed that I could book her another appointment to follow this up.

A week later she told me about growing up in a home where her father had been very controlling and frequently demeaned and verbally abused her mother, and to a lesser extent her. Her panic attacks had significantly worsened after the death of her mother eight years ago and she agreed that the opioids were not really being used for her RA pain now but to deal with her mental health issues.

A referral for CBT was arranged and we discussed how best to deal with her medication. She felt it would be difficult to slowly reduce what she was currently taking as she felt out of control with the Oramorph, and the decision was made to start her on buprenorphine. This has been titrated and she has stabilised on 6mg, which we are going to start slowly reducing while continuing her CBT.

Maria is a reminder that opioids are not only good painkillers but have psychological effects as well, and life events that can increase the risk of illicit drug use can also make dependence on prescribed medication more likely. The key is assessing these at the outset and using ongoing monitoring to try to avoid strong opioids from readily ending up on repeat prescriptions.

Steve Brinksman is a GP in Birmingham, clinical lead of SMMGP, and a member of the Opioid Painkiller Dependence Alliance, www.opdalliance.org

MEDIA SAVVY

The news, and the skews, in the national media

THE LAWFUL PHARMACEUTICAL INDUSTRY in the United States is the most insidious, vile and addiction-provoking monster of its type on the planet. Until it is properly confronted and curtailed, the migration of addicts from legal highs to heroin hell will continue at its fast and furious rate. My real wrath [is] aimed squarely at every politician and doctor who has enabled this horrendous scourge on society by encouraging Americans to medicate themselves in such a disastrously excessive and unnecessary manner.

They've created a real life *Walking Dead*.

Piers Morgan, *Mail*, 9 September

THE NHS HAS NEVER BEEN GOOD at engaging with excluded populations and delivering services to challenging individuals. Offenders, the homeless and people with fragile mental health, as well as drug users, often have no GPs, make themselves unwelcome at A&E departments, and miss appointments, and the complexity of their health needs is ill-matched to a system structured around specialities. Too often the very people who need the NHS most are those least able to navigate its various pathways.

Paul Hayes, *Guardian*, 9 September

WHILE [RODRIGO] DUTERTE'S OBSESSIVE WAR on narcotics may be horrifying to an international audience, for many Filipinos – even those ambivalent to his presidency – a 'some action is better than no action' stance has made a welcome change of pace... Duterte's victory came as the Philippines' drug problem was becoming so endemic that a firebrand, cartoon character of a president taking a sledgehammer to the issue became a reasonable gamble... Duterte's mass execution of the low hanging fruit in the Philippines drug trade will serve only to highlight how drugs have filled the vacuum created by successive governments. Filipinos did not vote for Duterte; they voted for a jab at the establishment that has, for the past five decades, consistently let them down.

Joanna Fuertes-Knight, *Guardian*, 16 September

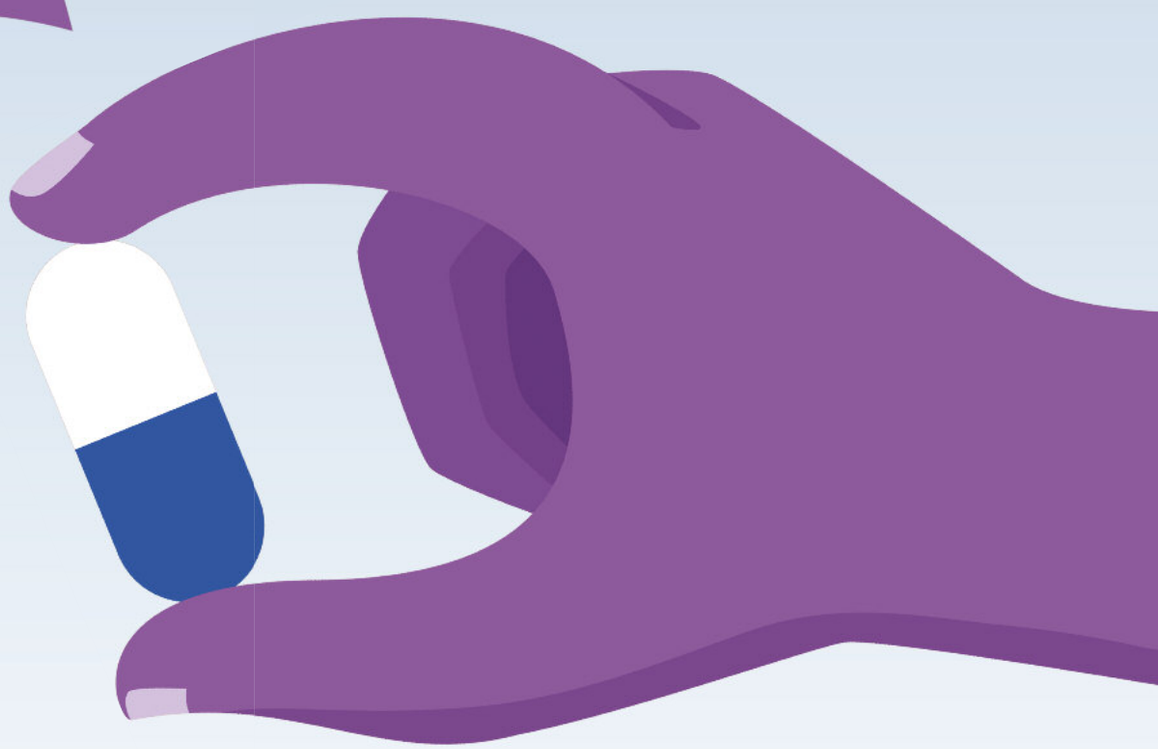
WHY DO SUCKERS ALWAYS FALL for the claims of 'medical cannabis'? Its advocates are invariably mixed up with the lobby for general legalisation... Cannabis may make some people feel better, but so did Thalidomide. A drug correlated with severe mental illness may just not be the ideal miracle cure.

Peter Hitchens, *Mail on Sunday*, 18 September

PAINKILLERS

Spreading

In the concluding article in a three-part series, **DDN** looks at much-needed services offering information and support



Buying codeine-based cough medicine from the chemist was David Grieve's path to addiction. At the time, manufacturers combined codeine with ephedrine – 'a similar effect to amphetamines', he says, and by the time he realised he needed help he was seriously ill.

Struggling through treatment with very little help, he set up the support service Over-Count to help others who find they have a problem with over-the-counter medicines. Back in 1993, when he started it from his front room, it was a tiny organisation with no funds. Sadly, he says, the situation hasn't changed much – but the problem of opioid painkiller addiction has grown out of all proportion.

'Since we started Over-Count in 1993, the amount of people we've helped is getting on for 80,000,' he says. 'About 1,000 people a year are coming in presenting with addiction to painkillers.' They range in age from 18 to 69, and three-quarters are female.

'About 95 per cent of the products they are addicted to are codeine-based painkillers,' he adds, with Nurofen Plus overtaking Solpadeine Plus as the pill of choice. 'The reason is quite simple – Nurofen Plus has 12.8mg of codeine in it, compared to 8mg, so you get more for your money.'

The amount of tablets being taken varies from six to 74 day – 'a dose that would kill me and would kill you'. In this case, the woman gradually increased her intake to 12 tablets six times a day, with a couple more doses in the night, and came to Over-Count 'as a last resort'.

In this extreme case, Grieve gave the woman a letter to take to her doctor, to help her get immediate medical support and liver function tests. For others,

More on painkiller addiction at www.drinkanddrugsnews.com

the word

the support begins in different ways and through the offer of a withdrawal programme, which 'has an 86 per cent chance of succeeding' and leaving the patient drug free for at least six months.

'If you can do six months, the chances are you can carry on drug free,' he says. The reason for the success rate, he believes, is that 'it feels personal and you're not just ignored and left to get on with it.'

Working constantly to prepare the individual programmes and respond to clients, Grieve does not have the time or money to continue his research or expand his database on the problem as much as he would like to. He is also deeply frustrated that his ten years of lobbying for a centralised information database and standardised treatment appears to have come to nothing, and warns that the problem will 'increase beyond recognition' over the next five years.

Director of DrugWise, Harry Shapiro, is equally surprised at the slow response to the issue.

'I did various Hansard searches and the subject has never come up – there aren't even any parliamentary questions on it,' he told *DDN*. 'It's completely ignored as a public health issue.' This is a situation he hopes to help change through the All-Party Parliamentary Group for Prescribed Drug Dependence, which considered his paper on opioid painkiller dependence and will dedicate its next meeting specifically to the topic, later this month.

The BMA is also holding stakeholder meetings, gearing up to lobby the public health minister to fund or run a national helpline – but he acknowledges that the mechanism can grind exceedingly slowly and that there's 'not a huge amount happening on the policy front'.

In the meantime, support organisations are developing the knowledge to offer much-needed help. Among these, DrugFam has the families' interests at heart, offering them a seven-day-a-week helpline, groups, and one-to-one support.

'It's about raising awareness so that they're not isolated and alone,' says chief executive Sarah Bromfield. 'Families don't always identify this as something they can get support for. So we need to raise awareness around GPs and the health services and around substance misuse agencies as well.'

Their latest initiatives, including developing leaflets, information brochures and a toolkit, came about as a result of an increasing number of calls to the helpline around the issue.

'We felt it was important that we did something about it,' she says. 'There are a lot of hidden families not getting the support they need.'

They have also joined the Opioid Painkiller Alliance, a group of organisations from the pain and addiction communities, which is campaigning for better screening, support and information for patients who are at risk of developing dependence.

DrugFam's information is being developed through talking to family members who are going through these issues and looking for common themes. An important element will be to help them tackle stigma, as well as the behaviours associated with any other addiction – 'so we need to help families at an early stage to put the boundaries in place and look after themselves,' she says.

Annemarie Ward, chief executive of Faces and Voices of Recovery (FAVOR) UK, agrees that being able to deal with stigma is a vital tool for both patients and families in tackling addiction.

'Opioids, whether prescribed, bought over the counter, or bought on the streets, don't discriminate,' she says, 'but people certainly do, which prevents people from reaching out for help when they most need it. Like most people with substance use disorders, those with opioid dependence take their problems underground and don't seek help early because they're worried about the ramifications for their careers, or they're ashamed to tell their families and friends.'

There are plenty of ways to challenge this stigma by offering compassionate support, both to the individual and to their loved ones, she says. 'Simply being kind and non-judgemental to people who are in an incredibly vulnerable situation can go a very long way.'

Last month's Opioid Painkiller Addiction Awareness Day (22 September) highlighted that there is a long way to go to start tackling this problem seriously – not just because of growing numbers of people affected. Searching for activity related to the campaign reveals very little and there was a lack of cohesive action to get the message across to the public and find those in need of help.

'Like most people with substance use disorders, those with opioid dependence take their problems underground and don't seek help early because they're worried about the ramifications for their careers, or they're ashamed to tell their families and friends.'

Over this series of three articles we have seen that progress for this patient group is hampered by lack of reliable data, inconsistency in professional practice and protocols, underfunded initiatives and a lack of political will to grasp the agenda and move it along. On the plus side, there are individuals, groups and services out there that are working with a passion to raise awareness and offer a lifeline to those who are addicted.

This article has been produced with support from Indivior, which has not influenced the content in any way. More information on opioid painkiller dependence at www.turntohelp.co.uk

THE DISCOVERY OF RECOVERY

Since 2008 'recovery' has been at the heart of British drug treatment policy. As **Mike Ashton** reports, it has been used as both an inspirational call to overcome addiction and a justification for limiting treatment

Though the term has a long history associated especially with 12-step-based approaches, the modern 'recovery' era in Britain can be dated to May 2008, when governments in Scotland and England presented it as a new dawn, which would reinvigorate treatment services stuck in the rut of preventing harm and crime rather than redeeming and regenerating lives.

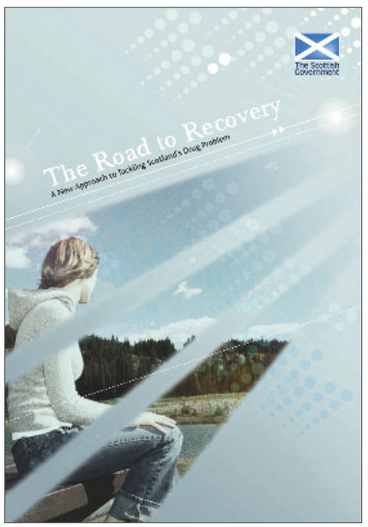
In an 'age of austerity', commentators have noted that the ambitious rhetoric was not matched by the 'intensive support over long periods of time needed to become drug free'. Though incorporated in genuine patient-centred advocacy, at a political level, in England 'recovery' helped legitimise not intensification, but withdrawal of support, as long-term treatment became stigmatised as impeding recovery. This article offers a reminder of that part of its origins which lay in the imperative to cut public spending and curtail addiction treatment – not to do more, but to spend less. Neglected in the dazzle of the recovery vision, these origins remain active in today's conceptualisations and uses of the term.

So dominant has recovery become, that it lies at the heart of the treatment themes in Britain's national drug policies. It features in the titles of both the English and the Scottish strategies, while the Welsh strategy committed the nation to 'focus our efforts on helping substance misusers to improve their health and maintain their recovery'.

What these strategies meant by 'recovery' was not spelt out, but the broad themes were clear: some of the most marginal, damaged and unconventional of people were to become variously abstinent from illegal drugs and/or free of dependence and (as Scotland's strategy put it) 'active and contributing member[s] of society'. Scotland's ambition echoed those of the government in England dating back to the mid-2000s for more drug users to leave treatment, come off benefits, and get back to work – and become an economic asset rather than a drain.

At first, under Gordon Brown's Labour government this ambition verged on the brutal. In February 2008 Labour's UK drug strategy seemed to threaten drug users reliant on benefits with penury if they failed to 'move successfully through treatment and into employment'. The backdrop was the credit-crunch crisis dating from August 2007, followed in April 2009 by a promise by Conservative Party leader David Cameron to usher in an 'age of austerity' to cut the budget deficit.

Though transition out of treatment and into employment was close to what later became 'recovery', of the six times that word was mentioned in the 2008 strategy, all but one referred to recovering financial assets from drug dealers, not recovery from addiction. South of the Scottish border, 'recovery' had yet to be discovered, but already preparations must have been underway to make it the dominant theme in the May 2008 Scottish strategy. That month too, in England the initial stress on reintegration through employment, enforced by withdrawal of benefits, had in senior government circles morphed into a more appealing label: 'recovery'.



'The initial stress on reintegration through employment, enforced by withdrawal of benefits, had in senior government circles morphed into a more appealing label: "recovery".'

In this, Labour was not just catching up with Scotland but also with the Conservative opposition. In July 2007 David Cameron's 'New Conservatives' had released the fruits of their addictions policy think-tank. In contrast to Labour's strategy, 'recovery' was the banner for its overarching philosophy. For treatment in particular, 'The ultimate goal... should be recovery and rehabilitation through abstinence.' It required 'radical reform' entailing a move away from substituting legal for illegal drugs and 'facing the fact that abstinence is the most effective method'. Not much survived of what would have been an expensive shift to residential rehabilitation and the structural reforms the report saw as needed to pursue recovery. But recovery itself, and the associated abstinence objective and denigration of maintenance prescribing, became embedded in Conservative thinking – and with the advent of David Cameron's government in 2010, in national policy.

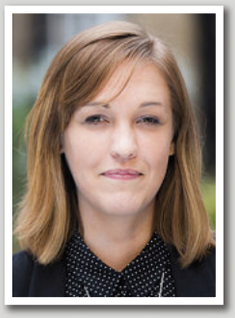
The strands later to be woven into the English version of recovery had, however, been gathering several years earlier, prompted in the mid-2000s by the felt need to make economies in addiction treatment and contain public spending – especially the welfare benefits on which the patients overwhelmingly relied. Though total funding was increasing, per patient funding had been falling for several years when in 2005 an 'effectiveness' strategy developed by the National Treatment Agency for Substance Misuse (NTA) complained of the 'lack of emphasis on progression through the treatment system' leading to 'insufficient attention... to planning for exit'. Foreseeing a time when funding would be less available, the agency's board was told that 'Moving people through and out of treatment' would create space for new entrants 'without having continually to expand capacity'.

Opposing the previous stress on retention – the yardstick on which services were then being judged – in 2007 this new emphasis on treatment exit was given an unwelcome boost when the prevailing crime-reduction justification for investing in treatment was challenged by the BBC on the grounds that treatment should be about getting people off drugs. There was no gainsaying the seemingly incriminating fact that in England in 2006/07, just 3 per cent of drug treatment patients had been recorded as having completed treatment and left drug free. The shock of that challenge and the economising turn away from retention to treatment exit fed through to the following year's national drug policy. Announcement of a three-year standstill in central treatment funding until 2011 – a real-terms cut when the caseload was expected to rise – further focused attention on squaring the circle by getting more patients to leave as well as enter treatment.

By then firmly linked to the term 'recovery', in 2014 the emphasis on treatment exit remained in government circles, eliciting a robust defence from the Advisory Council on the Misuse of Drugs (ACMD) of long-term opioid substitution therapy for heroin users. The following year the Conservative Party's election manifesto made it clear that the council's message had been rejected, continuing in the name of 'full recovery' to condemn 'routine maintenance of people's addictions with substitute drugs'.

Mike Ashton is editor of Drug and Alcohol Findings, http://findings.org.uk. This article is abridged from http://findings.org.uk/PHP/dl.php?file=reint_recover.hot&s=dd which offers links to source documents and also explores the meaning of recovery and its implications for treatment services.

LEGAL EYE



Nicole Ridgwell of Ridouts answers your legal questions

I'm about to accept a new job offer and would rather not disclose the medical treatment I'm receiving. It does not affect my ability to do the job. Am I obliged by law to fill in my medical form accurately?

NICOLE ANSWERS: **Section 60 of the Equality Act 2010** largely prevents employers asking candidates to complete pre-employment health questionnaires or to answer health-related interview questions at the recruitment stage. There are exceptions to this rule, for example where an employer asks whether candidates require reasonable adjustments to attend interview or whether they are eligible for the 'guaranteed interview scheme'.

Once a candidate has received a job offer, employers can ask questions to confirm that the candidate's health would not prevent them from doing the job. Candidates are not obliged to disclose health problems unless they are asked a direct question.

The Equality Act does not prohibit employers asking candidates to engage with occupational health assessments once a job offer has been made, nor does it prevent employers from asking for GP reports. Employers cannot obtain GP reports without candidate consent and candidates can ask to see reports before employers do. Where a candidate disagrees with a report, they can ask for it to be changed and, if not changed to their satisfaction, can stop it being sent on. If a GP report is part of the employer's recruitment process and they do not receive it because the candidate objects, the employer can legitimately withdraw the job offer.

Candidates may be understandably hesitant in sharing health information with future employers. However, it is important to remember that, through disclosure, the applicant gains the protection of the Equality Act. The Act covers all physical or mental health problems lasting for 12 months or more and, while it does not cover addictions *per se*, it does cover secondary health conditions resulting from addiction problems.

Once an employer is aware, they must make all reasonable adjustments, such as changes to working hours or the environment. Employer knowledge can also assist the employee with otherwise difficult conversations, such as asking for a reduced workload at times or for time off for doctors' appointments.

Conversely, if an employer directly asked questions about health and the candidate did not answer or did not answer truthfully, this could later form grounds for disciplinary action against the employee.

Where an employer is concerned that the disclosed status may affect the candidate's ability to meet the job requirements, the employer must follow up with occupational health or the candidate's GP. If the job offer is withdrawn after disclosure but without follow-up, this may be grounds for a claim of disability discrimination.

If considering disclosing a health problem, candidates would be advised to talk to their doctor or other health professionals about the language they could use. It may also be useful to contact an organisation that supports individuals with the relevant health issue and seek their advice.

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

DDN HELP

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Here's a taster of services From DDN Help. To find out how to be featured online and in DDN Magazine, contact ian@cjwellings.com

RESIDENTIAL TREATMENT

SEFTON PARK

Sefton Park
For addiction treatment that works

Sefton Park is a residential alcohol and drug rehabilitation centre and therapeutic community, founded to help people who have made a conscious decision to free themselves from their addiction.

Developed over the past 21 years, the six-month programme requires individuals to explore past and present issues, looking deeply into how these relate to the cycle of addiction and connected behaviour. By understanding these issues and by challenging negative attitudes, an individual may gain the insight they need to make informed lifestyle choices.

The team at Sefton believe that everyone has the right to change their lives, enjoy a healthy lifestyle and develop themselves to the maximum of their ability.

SUPPORT GROUPS

ARTHEADS

a right bunch of... artheads

Artheads is a voluntary organisation based in Bury St Edmunds that is committed to helping anyone with drug, alcohol and mental health issues through creativity and imagination.

The project provides a safe, alcohol and drug-free place in which everyone can take part in all kinds of creative art and music activities. Activities aim to engage the whole community in challenging stereotypes and misconceptions around addiction problems.

Find details of all of these services, plus what is available in your area, at www.ddnhelp.com

ADDING A LISTING IS FREE
ADD YOUR SERVICE TODAY

COUNSELLORS AND THERAPISTS

STUART DOWNING

Stuart is a clinical hypnotherapist, master hypnotist and certified practitioner of NLP and EMDR. Working within the addictions field, he helps people make meaningful changes to improve their health and wellbeing.

Hypnotherapy is a safe and natural way of engaging on a subconscious level with some of the root causes of a client's addiction. The change must come from within, but using hypnotherapy he can help people to make the changes they are looking for.

Stuart offers a non-judgemental empathetic approach, and provide clients with a confidential service in locations across the UK, Spain and also world-wide using Skype.

RESOURCES

DRUGWISE

The mission of DrugWise follows very much in the tradition of DrugScope – to provide drug information that's topical, evidence-based and non-judgemental. In addition to providing updates and new reports, the site includes links to DrugScope archive materials and all Druglink articles back to 1986.

Created by Harry Shapiro and his former DrugScope colleague Jackie Buckle, the site hosts an updated library of policy and practice materials, and the popular DS Daily morning email update service.

PHARMACIES

BOOTS

Boots UK Limited, trading as Boots, is a pharmacy chain in the United Kingdom and Ireland, with outlets in most high streets, shopping centres and airport terminals. Drug and alcohol provision includes supervised consumption of methadone and buprenorphine and needle exchange. You can find the details of services provided by your local store on www.ddnhelp.com

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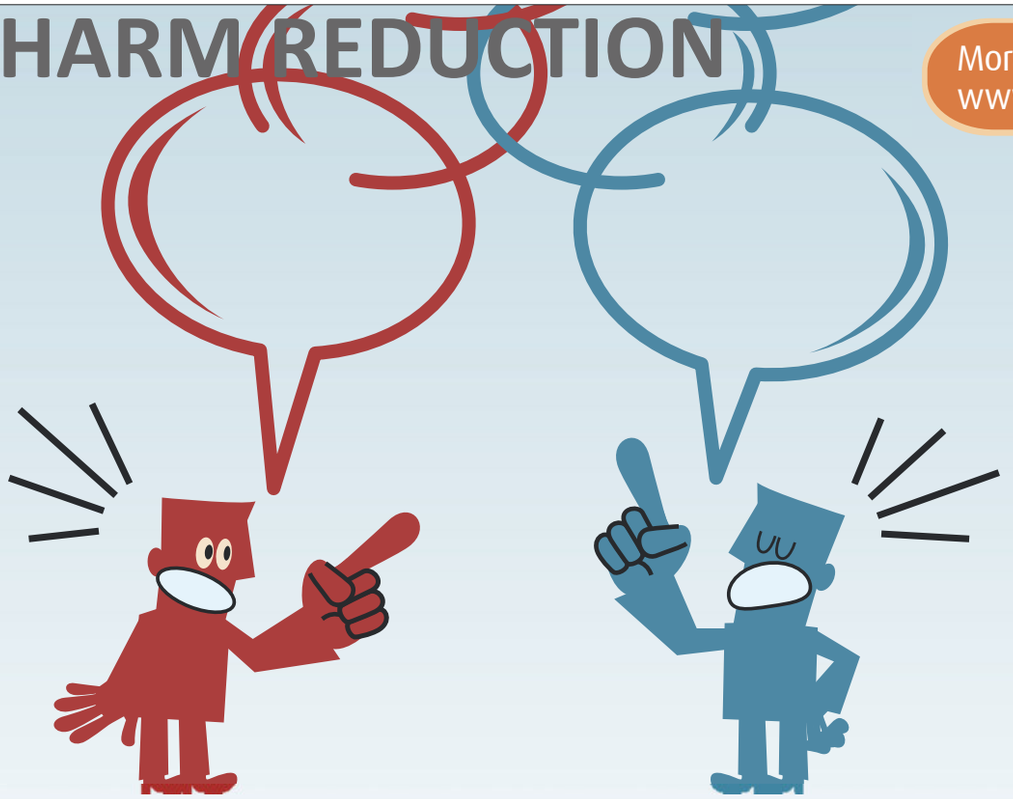


It's not enough to just present the evidence... you have to engage with the values and morals of those who oppose you

LET'S GET RADICAL

Harm reduction measures can be seen as controversial within the wider population, but isn't confronting public fears an essential stage in moving the agenda on? *DDN* reports

'HOW RADICAL CAN HARM REDUCTION BE?' asked Dr Ingrid van Beek at the *City health 2016* conference in London. Van Beek was part of the team that established what still remains Australia's only drug injecting facility, in King's Cross, Sydney in 2001. The fact that no other Australian facilities have been set up in the last 15 years makes the King's Cross site appear more radical than it really is, she argued.

The site was chosen as there was a large amount of street use in the area, and was established as an extension of needle exchange services. While these services are now seen as mainstream, with more than 90 countries providing needle exchanges, establishing safe clinical settings for people to inject drugs is still sometimes seen as 'a step too far'.

'What did you think was happening with all the needles being given out?' was a question van Beek had asked politicians and local residents also opposed the scheme. Lobbying against a backdrop of cheap heroin, rising drug-related deaths, and an increasing amount of visible street users, she had finally persuaded politicians to confront the problem and agree a trial period for the new facility.

Despite the scheme being the most evaluated medical facility in the world, with its positive outcomes in reducing both fatal overdose and street use validated by independent assessment, its trial status remained for nine years before it finally became a permanent service.

It's not enough to just present the evidence, van Beek told delegates – you also have to engage with the values and morals of those who oppose it. Shutting it would ultimately have resulted in an increase in overdose deaths, something that opponents needed to be reminded of. 'I think we should keep people alive, and make no apology for it', she said.

Harm reduction facilities are never more needed than in times of austerity – but unfortunately the short-term costs could prohibit establishing these interventions, said Dr Konstantinos Farsalinos, of the Onasis Cardiology Centre in Greece. Providing delegates with a perspective on Greece since the financial crisis, Farsalinos talked of the massive reduction of GDP and huge increase in unemployment, which had especially hit young people and the poor, and had seen an associated rise in drug and alcohol use, accompanied by more cases of blood-borne viruses and mental health issues.

One of the problems was that effectiveness of harm reduction services could often only be proven over the long term. Coupled with a lack of public sympathy for some client groups, this could make it hard to secure initial funding, said Farsalinos.

Professor Neil McKeganey of the Centre for Substance Use Research urged caution around seeing harm reduction as a universal panacea. Interventions should be limited by both evidence of cost effectiveness over a long term, and also the moral and political limitations required by the wider population, he said.

Harm reduction was not a call to arms but an important societal movement, said McKeganey, and it was important that it was judged with the same critical measures used on any other health intervention.

One of the main challenges according to Jamie Bridge, of the International Drug Policy Consortium, was that 'people who use drugs are now widely seen as criminals, not as people who need support'.

Campaigns such as *Support. Don't Punish* were proving successful at bringing grassroots partners into the debate and gaining the attention of the media – both vital in reaching new audiences and influencing policy.

Drug policy had been 'a public health disaster around the world', he said, and decriminalisation was the only way forward.

Why wait for the death toll to rise, asks Nigel Brunsdon

With overdose deaths recorded every week in the UK, safer spaces were disappearing fast but needed more than ever, Nigel Brunsdon told the National Substance Misuse Conference, *Breaking down barriers*.

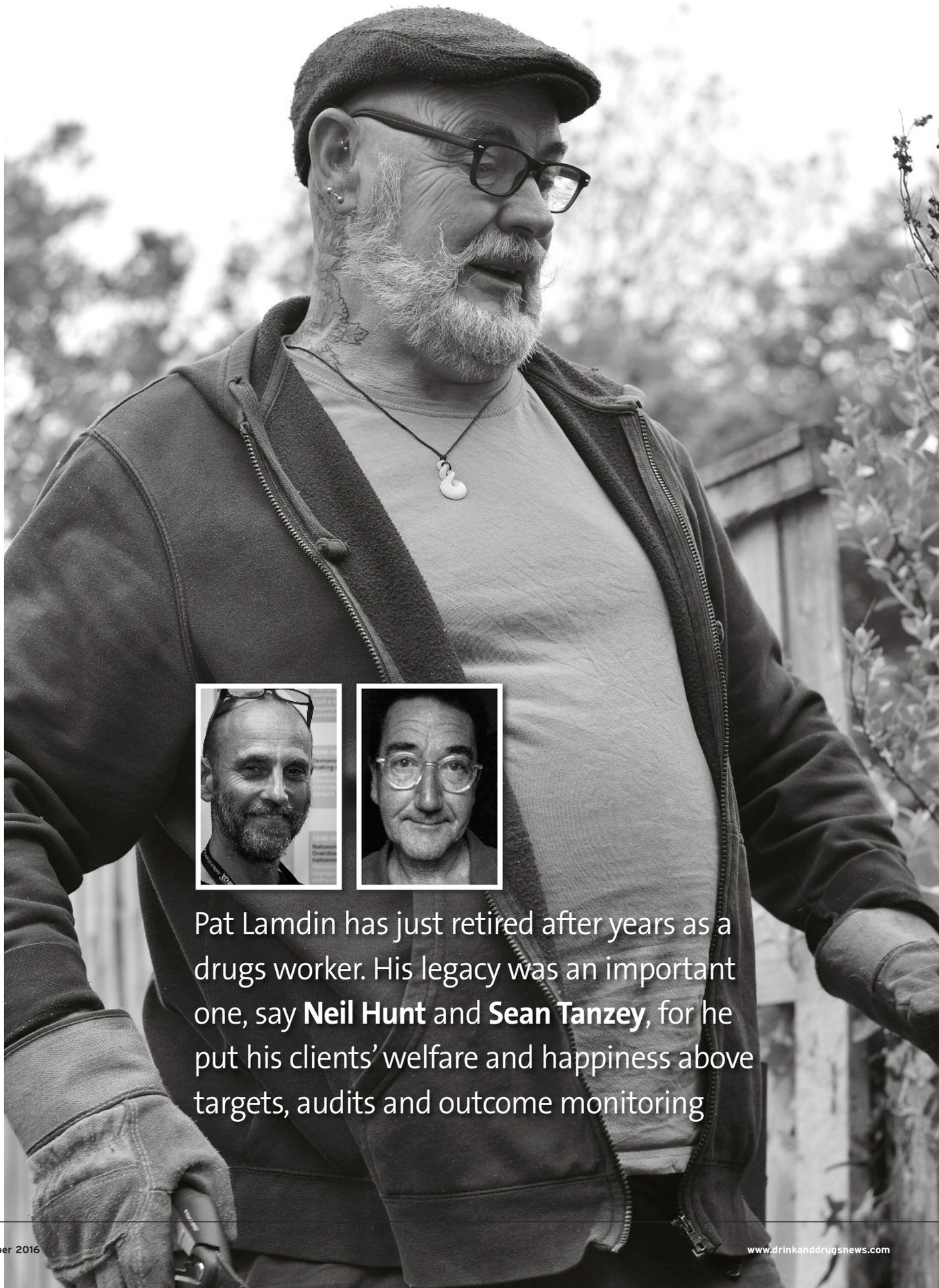
Needle exchanges were closing all over the country and transferring to pharmacies, and the lack of political will to open consumption rooms in the UK made no sense: 'There have been zero deaths in them anywhere in the world, and they've been open since 1986,' he said. Slowing slides of filthy and unhygienic spaces full of needle litter, close to where the conference was being held, he added 'Birmingham has an overdose fatality every week'.

Beyond reducing deaths, the facilities were also shown to reduce blood-borne viruses and increase access to treatment, housing and other forms of engagement.

'We have the highest levels of drug use ever and many people who've never been in treatment,' he said. 'So why aren't drug services clamouring to do this?'

More reports from the NSM conference in next month's issue.

The HEART of the matter



Pat Lamdin has just retired after years as a drugs worker. His legacy was an important one, say **Neil Hunt** and **Sean Tanzey**, for he put his clients' welfare and happiness above targets, audits and outcome monitoring

Old fat bloke retires; so what? Happens every day, why does it matter? It matters when people like Pat Lamdin retire, because we're not making them like that any more.

When the careers of people devoted to public service come to an end there is something of a bias towards publicly honouring the accomplishments of people who have long since 'progressed' and moved on from their original vocation: typically, to a series of successively better paid, higher status leadership roles.

Other exceptional careers, however, are based on deliberate and sustained efforts to avoid promotion (despite regular encouragement) because promotion would inevitably be a distraction from a calling and particular talent for working with people experiencing problems with alcohol or other drugs.

Pat Lamdin's practice warrants celebration in these pages for this reason. He worked directly with this population until he retired – not because he was someone who lacked ambition, but because his simple yet worthy desire was to continue doing the work he had chosen to do many years earlier. Doubtless this was one of the reasons he always seemed so bloody good at it.

It takes an unusually dedicated person to choose to do this and spend pretty much their entire working life in counselling rooms decorated in the bland 'shabby magnolia and woodchip chic' historically favoured by the voluntary sector. If you doubt this, just ask yourself how many retirement parties you have attended for people who have worked more or less continuously in such ill-paid positions.

Regarding which, Pat never had much time for the treatment sector's seemingly endless enthusiasm for semantic navel gazing about what to call its workforce or the people it aims to help. He seemed less bothered than most about whether his job title said he was a psychiatric nurse, counsellor or prescribing or recovery worker. Or whether the people with whom he spent most of his time were now called patients, clients or service users. Probably this was because, whatever terminology was used to describe it, he always had an unswerving sense of what his work entailed – meeting people on their terms and helping them as best he could.

As numerous colleagues from across the years would attest, Pat was an exceptional colleague who had as much time for the administrators as for the chief executive. When practitioners and the occasional researcher sought his advice, this would frequently be as wise as it was blunt.

What special qualities does Pat have? This is an important question. When talents like Pat's leave the workforce due to retirement (or other causes) it is vital that they are replaced by new practitioners with the skills necessary to those who need help. All that can be done here is to refer to a couple of aspects of how Pat worked.

You know those rare people you meet who immediately engage with you fully and often leave you feeling curiously better about yourself? Well Pat is one of those. Perhaps the capacity to do this is that thing known as 'unconditional positive regard' (UPR), which many aspiring counsellors first learn about in *An introduction to counselling skills?* But establishing the therapeutic alliance is a profoundly important skill that a good practitioner develops throughout their working life. Pat would cheerfully tell anyone who would listen that no care plan ever saved a life, but skilled workers could do. And, he would say, if you were still listening, you don't give workers skills by just giving them a manual to work from.

The treatment field has a mountain of controlled trials comparing 'this therapeutic model' versus 'that therapeutic model' and the only consistent finding is that interventions tend to be much of a muchness. As it turns out, the variable that explains the largest difference in outcomes is 'therapist factors', *ie* what that person is like and how they treat you.

This is why people with this remarkable talent for UPR are so valuable in the workforce. After all, it isn't a giant leap of logic to suppose that, if a practitioner immediately enables a client to feel genuinely valued, safe, and perhaps a bit better about themselves, then perhaps they'll feel more ready to talk about something they find incredibly difficult for the very first time, or stick with doing something that is very difficult to do, or go away and attempt something they didn't believe they could do?

He was walking proof that being a corpulent, 6'1" bloke with a pink Mohican and an ear expander big enough to pass your granny through (plus her handbag) is no barrier to engaging with people at any stage of their life, if forming the therapeutic alliance is uppermost in your mind.

There seemed something about this combination that almost instantly reassured people who were nervously attending their appointment. It says, this is someone who seems unlikely to be judgemental, or shocked by any revelations, however shameful. On the contrary, it's easy to imagine his own past might contain a few demons and a little shameful behaviour too. Or maybe quite a lot. Though whether that is true, it's probably not the sort of thing to reveal in an appreciation of someone's career.

Strangely, this Renaissance prince of the liberal humanities wasn't universally popular. If managers required Pat to attend a meeting, he would take gleeful pleasure in requiring them to listen to what he had to say. Over and over again. Our clients deserve workers with skills beyond completing paperwork. Groups are highly difficult treatment approaches, not a cheap option beginners can run unsupported. Data is a tool, not an objective. Not music to every manager's ears.

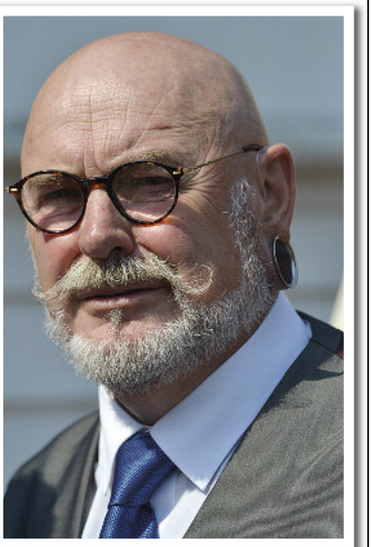
But let's salute a contribution made over four decades, across the NHS and voluntary sectors. As a seasoned marathon runner, Pat knew about staying the course, in mental health, homelessness and substance misuse, which demonstrates a level of commitment and resilience few sustain at the client-facing level.

Committed, because although the work can be hugely enjoyable when you work with people who at times can be wise, witty, heroic and much more (such as the epically strange); it also requires being a witness to a relentless flow of lives blighted by tragic and traumatic events with the intractable problems that follow.

Resilient, because when you are an expert at your craft who has studied extensively to obtain the necessary qualifications and also acquired the subtler, sophisticated understanding that can only be obtained by spending thousands of hours talking to hundreds of people... well it can be bloody annoying when policies and procedures seem to be constantly changed for no discernible good reason by people you sometimes suspect haven't a clue what your work entails. Or because your employer has suddenly changed, though your clients haven't. Or the irritation of dealing with the 'bean counters' and the ever-increasing demands on your time from their array of clinical audits, activity monitoring forms, outcome tools and other performance monitoring data, much of which seems ill-conceived, irrelevant and a hindrance to doing your work in the way clients need.

When Pat left, some of his clients wept. No manager did.

He'd settle for that.



You know those rare people you meet who immediately engage with you fully and often leave you feeling curiously better about yourself?

HOW I BECAME A...

SOCIAL WORKER FOR SUBSTANCE MISUSE

Combining her two key interests brought *Hannah Feeney* to The Alcohol and Drug Service (ADS) as an advanced social work practitioner

I CAME INTO SOCIAL WORK BY ACCIDENT at age 19 when I had completed my A levels and was trying to work out what I wanted to do with my life. I was advised that doing a counselling course would equip me with communications skills that would benefit me in any job, so off I went to complete a ten-week course.

This was my first experience of listening to people who were in emotional pain and started my pathway towards working with people who were facing adversity and needed professional support.

When I began a degree in social work, I don't think I really understood where it would take me. But I came to learn that it is a profession that engages with people at some of the most complex and challenging periods of life where hopelessness, fear, isolation and distress are common – not just for the individuals, but also in their families, children and wider communities.

I was inspired by the area of substance misuse services very early on, through completing a specialist module and practice placement. I saw the widespread impact of addiction and was humbled by the sheer determination people had to find to achieve independence and wellbeing.

I started my first job in a drug intervention programme – a qualified social worker, employed as a drug and alcohol worker. I used social work skills on a daily basis to engage with people, assess their needs, and help them to plan their care and achieve their goals, but was discouraged from sharing my professional identity due to a belief within the organisation that service users would not engage with social workers.

I began to see the lack of understanding in society of my profession, and the misconception that all social workers were people to be suspicious of. Being part of someone taking control of their life and thriving in recovery was rewarding and I knew I had made the right decision to work within this sector, but I was keen to retain my professional identity.

In 2006 I had the chance to take on a role that incorporated the two things I had developed a real passion for, and I became employed by a local authority as a specialist social worker for substance misuse.

This gave me an opportunity to focus on developing my social work skills further, and over the next six years I saw the substance misuse field change and grow following the introduction of the recovery agenda. As services have been recommissioned and austerity has hit, service providers have been reconfiguring their staffing, leadership structures and their use of peer support and mutual aid, while supporting people to build recovery in their communities.

The social work profession has also seen huge reform, new legislation and workforce challenges, bringing it closer to the substance misuse sector than ever before. There is now a real opportunity for social work to support the recovery agenda with its underpinning principles of empowerment, self-efficacy and community cohesion.

I currently work as the social work lead for The Alcohol and Drug Service (ADS). Like many providers, ADS has employed social workers for many years but began thinking closely about its workforce several years ago as it formed partnerships with NHS trusts. Leading on the social care element of the services they provide, ADS made a decision to use the skills and accountability of social work professionals to lead the frontline workforce, developing reflective practice within their teams and contributing to the skills development of others.

My role is therefore to build and lead a social work structure across the organisation's partnerships that is robust and enables career progression, is in touch with national policy and governance and is constantly developing and adapting to the change that reform brings.

Alongside the strategic element of my role I am responsible for enabling, monitoring and evaluating continuing professional development (CPD) from social work placements, through the assessed and supported year in employment (ASYE) and into post-qualifying learning and development. As a practice leader for the social work professionals that ADS employs, I thoroughly enjoy watching them thrive in their professional roles within our services. One of our social workers said, 'As a recognised social worker I have begun to bring other areas of my training into my work, including reflective practice and the confidence to challenge other professionals... it is greatly appreciated that we are recognised in the sector that we work in.'

The social work team at ADS are now spread among our services, supporting the holistic approach required for effective recovery-focused services. We engage with and contribute to a number of university social work programmes and fast-track schemes, giving our social workers opportunities to develop other skill sets that are valuable to them and the organisation. ADS holds a strong belief that social work as a profession has a key role to play in the future of substance misuse services and I feel great excitement about what this could mean for our workforce and the wider substance misuse field, for social work – and ultimately for the people who need and use our services.

'The social work profession has also seen huge reform and workforce challenges, bringing it closer to the substance misuse sector than ever before.'

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A MODEL OF CHOICE

It's time for a paradigm shift in our view of addiction, says **Dr Julia Lewis**

TRENDS COME AND GO and nowhere more so than in the shifting world of addiction management. The pendulum seems to swing from one paradigm to another with the supporters of each frequently baying for the blood of their opponents. Some support abstinence as the only sensible goal, and berate the so-called 'medical model' with its alleged transfer of dependence to state-endorsed substances, while others shout loudly in support of what they claim is a more inclusive harm reduction approach.

But what if there was a model that encompassed all these laudable ideas and then took things a stage further?

In 2007 the World Health Organization called the management of chronic disease (such as asthma, diabetes and hypertension) 'one of the greatest challenges facing healthcare systems throughout the world'. Out of these concerns developed the chronic disease management (CDM) Model defined by the Disease Management Association of America as 'a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant'.

Various researchers have argued that this model can be applied to the management of addiction, as evidence suggests that addiction has a similar profile to other chronic diseases. For instance, more than half of patients entering publicly funded addiction services in the USA achieve and sustain recovery after multiple episodes of treatment over several years, and addiction is associated with chronic physiological changes; a relapsing, remitting course; comorbidity; a need for ongoing care but with variable adherence to that care; and the absence of a 'cure'.

Current models of addiction treatment provision in the UK frequently follow an acute care model, concentrating on the management of complications of use as opposed to the underlying condition, and lacking essential coordination of care across health and social care systems. However, managing addiction solely through these acute episodes of brief stabilisation and detoxification can contribute to the frustration of service users, their families and the public regarding prospects for permanent recovery.

Also, as a chronic disease with biological, genetic and physiological elements, addiction should be addressed via a case-managed combination of treatment modalities, personalised to the assessed needs of the service user, providing an integrated pharmacopsychosocial approach to treatment.

In contrast, the CDM model bases care on the service user's needs, values and decisions, rather than reacting to problems. Nevertheless, transferring the CDM approach to the management of addiction requires a move into a recovery-oriented system and the recovery management (RM) model has been developed to combine these two treatment paradigms.

So, what are the essential features of an RM model of addiction treatment?

The model is easy to access and geared to developing motivation. The care planning process focuses on the whole life of the service user, not just the problems caused by their use, and supports their right to manage their own condition. The clinician is seen as an educator, providing long-term support, and a comprehensive care plan brings together services best placed to address their needs. Interventions are evidence-based and include all relevant modalities, and the emphasis going forward is on self-management, with links to recovery resources in the community and easy access to re-intervention if needed.

It is possible that the RM model provides us with an integrated system of tried and tested addiction treatments but in a way that wraps the management plan around the service user, connects them effectively to other relevant parts of the health and social care system and draws on recovery resources in their community.

Accepting the chronic disease nature of addiction may be a difficult mindset shift for some, but to continue to attempt to address it via a model of acute, 'one-size-fits-all', circumscribed treatment not only does a disservice to our service users but also flies in the face of the evidence. It's time to adopt the new paradigm.

Dr Julia Lewis is consultant addiction psychiatrist for Aneurin Bevan University Health Board. This article is based on her talk to the SMTPC event, The post-war dream, held in Newport, Gwent.

Creating a shift in thinking from the traditional acute care models to the RM model is underpinned by the following concepts:

Addiction exists in transient and chronic forms. Transient forms may resolve spontaneously or with brief interventions alone. Chronic forms are associated with greater complications, more comorbidity and more obstacles to recovery.

Evidence shows us that, although recovery is an achievable goal, it takes around three to four treatment episodes over a period of eight years for this to occur.

If we see addiction as a chronic disease, we should not see previous treatment as a poor prognostic indicator, convey to service users the expectation of complete recovery after one treatment episode and punitively discharge service users who relapse.

Many people discharged from addiction treatment find themselves caught between recovery and relapse for weeks, months or even years, strongly supporting the need for ongoing post-treatment monitoring and support.

Multiple episodes of treatment, if integrated into a recovery management plan, can lead to cumulative effects and multidisciplinary interventions may have synergy.

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

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