

**DRINK AND DRUGS NEWS**

ISSN 1755-6236 **SEPTEMBER 2016**

**DDN**



# **BACK TO REALITY**

**HELPING THOSE WITH ALCOHOL-RELATED BRAIN  
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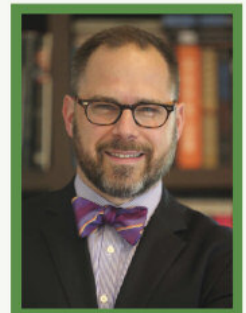
THIS  
YEAR'S  
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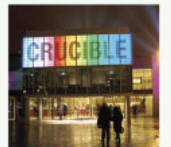
This year RiTC6 is looking at what happens beyond recovery - past the treatment, the structured groups, the wellbeing activities, the building of recovery networks - into the 'now what'. We'll be exploring recovery's role as an organisation's purpose; as a pro-society voice and as a building block for developing champions and community leaders out there in the 'real world'.

## KEYNOTE | PAUL SCHMITZ



From former drug dealer, to Obama's advisor on community solutions, Paul Schmitz is passionate about leadership and its role on the frontline solving community problems. This isn't leadership as we know it: 'top of the food chain', position of power stuff, but leadership as an action that many can take. Paul will bring his world-view (and signature bow tie!) to our keynote that promises to inspire but challenge us on our role as developers of leadership as a pro-social concept.

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## EDITOR'S LETTER



### 'Where else would you get new thinking, informative evidence and authentic personal experience?'

Welcome to our September issue; I hope you've had a good summer. We've got a varied menu for you this month – from a useful insight to the little-understood Korsakoff's syndrome (page 6) to a look at the major new project that could reshape our prisons (page 10).

The latest in our painkiller addiction series looks at some innovative treatment services to respond to this complex problem (page 12) and throughout the magazine we have some fascinating thoughts on the nature of addiction. Is it a learning disorder rather than a disease, as Maia Szalavitz suggests (page 14)? Will we listen to new evidence to reshape drug policy (page 15), asks David Nutt. We should promote the life-saving benefits of e-cigarettes, says Chris Ford (page 18). And what should be the purpose of harm reduction – as primary goal or to eliminate drug use? See Mike Ashton's article on page 16.

There's also a great reminder of the power of service user and recovery community involvement, through Jon Roberts' thriving peer-led enterprise on page 9 and an informative day for social worker students on page 19. Where else than in DDN would you get such a stimulating mixture of new thinking, informative evidence and authentic personal experience? All we need now is your letter!

And while you're visiting our website this month, check out our new 'DDN Help' treatment finder that we've been developing for members of the public. Please add a listing for your service, support group or resource – it's completely free of charge, just like the magazine.

Claire Brown, editor

Published by CJ Wellings Ltd,  
57 High Street, Ashford,  
Kent TN24 8SG

Editor: Claire Brown  
t: 01233 638 528  
e: claire@cjwellings.com

Publishing assistant:  
Millie Stockwell  
t: 01233 633 315  
e: millie@cjwellings.com

Reporter: David Gilliver  
e: david@cjwellings.com

Advertising manager:  
Ian Ralph  
t: 01233 636 188  
e: ian@cjwellings.com

Designer: Jez Tucker  
e: jezt@cjwellings.com

Webmaster:  
Aaron Denne  
e: aaron@cjwellings.com

Subscriptions:  
t: 01233 633 315  
e: subs@cjwellings.com

Website: www.drinkanddrugsnews.com  
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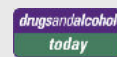
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## ‘A NATIONAL TRAGEDY’ – RECORD DRUG FATALITIES FOR SCOTLAND

**SCOTLAND HAS ONCE AGAIN RECORDED ITS HIGHEST EVER NUMBER OF DRUG-RELATED DEATHS, AT 706 – ALMOST TWO PER DAY.**

The 2015 figures are 15 per cent higher than 2014’s already record figure of 613 (*DDN*, September 2015, page 4), which itself was up 16 per cent on the previous year. Scottish Drugs Forum CEO David Liddell said the numbers were a ‘national tragedy for Scotland’ and ‘the ultimate indicators’ of the country’s health inequalities.

The total number of deaths now stands at more than double the amount recorded a decade ago, with males accounting for almost 70 per cent. More than 30 per cent of the deaths were in the Greater Glasgow and Clyde NHS area, and 73 per cent were among the over-35s. ‘One or more’ opiates or opioids including heroin/morphine and methadone were implicated in, or potentially contributed to, more than 600 of the deaths (86 per cent) – a higher figure than in any previous year.

While NPS were implicated in or potentially contributed to 74 deaths, only three were thought to have been caused by NPS alone. The figure for benzodiazepines, meanwhile, stood at 191 deaths and cocaine at 93.

‘The deaths are heavily concentrated in our poorest communities and if you look behind the lives of most people who have died you will find a life of disadvantage, often starting with a troubled early life,’ said David Liddell. ‘Rather than focusing on individuals and blaming their “lifestyle” we need to understand how we as a society have failed and continue to fail so many people.’



The statistics are ‘a legacy of Scotland’s drug misuse which stretches back decades.’

AILEEN CAMPBELL

The deaths were preventable, he stressed, but less than half of Scots with a drug problem were in treatment or care services at any one time. ‘We know that being in effective treatment protects people against dying of an overdose so we need to look at ways to increase the reach and retention rates of services. We also have to look at the quality of those services. These figures represent a national challenge to our image of ourselves and an opportunity to show that we, as a society, care.’

Addaction Scotland said that it was ‘deeply concerned’ by the figures, drawing attention to the ‘uncertainty of current and future funding’ of services and adding that provision of fixed-site needle exchanges – often the entry point for people to engage in treatment – had fallen.

The statistics were ‘a legacy of Scotland’s drug misuse which stretches back decades’, said public health minister Aileen Campbell. ‘We remain committed to tackling the scourge of illegal drugs and the damage they do to our communities, and to support those who are struggling with addiction.’

*Drug-related deaths in Scotland in 2015 at [www.nrscotland.gov.uk](http://www.nrscotland.gov.uk)*

chain but others believing they offer a ‘new, often young, consumer base easy access to drug markets’. *Internet-facilitated drugs trade at [www.rand.org](http://www.rand.org)*

## HEP HOPE

**ACCESS TO HEPATITIS C TREATMENT IS IMPROVING**, according to PHE’s annual figures, with 2015 treatment rates up 40 per cent on the previous year, alongside access to newer drugs. Around 160,000 people in England are living with the virus, says *Hepatitis C in the UK: 2016 report*. ‘It’s early days, but with more patients being tested and improved treatments, there is genuine hope that we are seeing an impact on the number of deaths from hepatitis C related end-stage liver disease and liver cancer,’ said publication lead Dr Helen Harris. *Available at [www.gov.uk](http://www.gov.uk)*

## CUSTODY CONCERNS

**DEATHS IN PRISON CUSTODY** in the 12 months to June 2016 were up 30 per cent on the previous year, at 321, according to figures from the Ministry of Justice. Self-inflicted deaths rose by 28 per cent, self-harm incidents by 27 per cent and assaults on staff by 40 per cent, spelling out the ‘urgent need’ for prison reform according to the Howard League’s director of campaigns, Andrew Neilson.



‘Prisons are becoming more dangerous more quickly’

ANDREW NEILSON

‘Prisons are not only becoming more dangerous, they are becoming more dangerous more quickly,’ he said. ‘The high levels of violence and deaths should shame us all, and the new secretary of state for justice and her ministers must set out concrete plans to reduce them.’

*Safety in custody statistics bulletin at [www.gov.uk](http://www.gov.uk). See feature, page 10.*

## END THE KILLINGS

**UNODC EXECUTIVE DIRECTOR YURY FEDOTOV** has condemned the ‘apparent endorsement of extrajudicial killing’ of suspected drug offenders in the Philippines by president Rodrigo Duterte, stating that it ‘does not serve the cause of justice’. Last month more than 300 NGOs signed an open letter asking UN drug control bodies to call for ‘an immediate stop’ to the killings, around 1,900 of which have been recorded since Duterte took office in May. Known as ‘Duterte Harry’ and ‘the punisher’, the president has encouraged vigilante action against drug users and dealers as part of his pledge to ‘eradicate crime’ in the country within six months. ‘This senseless killing cannot be justified as a drug control measure,’ said IDPC executive director Ann Fordham.

## CRYPTO CASH

**THE UK HAS THE SECOND HIGHEST NUMBER OF ONLINE DRUG VENDORS**, at 338, according to a report from the Rand Corporation – less than half the US total of 890 but higher than Germany’s 225. Total drug revenues on ‘cryptomarkets’ in January 2016 were estimated at between \$12m and \$21m, says the document, suggesting that they remain ‘niche’ marketplaces compared to the estimated \$2.3bn monthly offline drug market in Europe alone. The report finds ‘some evidence’, however, that drugs sold on the dark web are providing stock for offline dealers. ‘The evidence on the full impact of cryptomarkets remains inconclusive,’ said co-author Stijn Hoorens, with some arguing that they reduce violence from the drug supply



## DRINK LIMITS: MORE 'CLARITY' BUT CONTROVERSY CONTINUES

**THE GOVERNMENT HAS PUBLISHED THE FINAL VERSION OF ITS REVISED ALCOHOL GUIDELINES**, stating that both men should and women should drink no more than 14 units per week. The draft guidelines were issued at the start of the year (*DDN*, February, page 4) drawing criticism from parts of the media both of the levels themselves and some of the language used, such as that there was no safe level of drinking.

Although the guidelines took effect in January the Department of Health launched a consultation to see what the public felt about their 'clarity, expression and usability', while Public Health England carried out its own research into reactions to the document's tone and language. The new report states that the intention is to help people understand the potential health risks and make 'decisions about their consumption in the light of those risks', but not to 'prevent those who want to drink alcohol from doing so'. Chief medical officer Sally Davies drew criticism from some newspapers when she told a commons select committee earlier this year that she takes 'a decision' each time she 'reached for a glass of wine' – 'Do I want the glass of wine or do I want to raise my own risk of breast cancer?'

The new document states that for those drinking at or above the 'low risk level advised', the risk of dying from an alcohol-related condition would be expected to be 'at least 1 per cent' over a lifetime, making it comparable to 'those posed by other everyday activities that people understand are not completely safe yet still undertake'. However, the expert group was also 'clear that there are a number of serious diseases, including certain cancers, which can occur even when drinking within the weekly guideline', meaning there is 'no level of regular drinking that can be considered as completely safe in relation to some cancers'.

Alcohol Concern chief executive Joanna Simons said the guidelines were based on the views of independent doctors studying 20 years' worth of evidence and represented 'the maximum amount we can drink each week with little risk to our health', calling for a mass media campaign to make sure they were widely understood. Industry body the Portman Group, however, said that while the new document 'provided much-needed clarity' it was 'regrettable' that it still included a reference to there being no safe level of drinking, while the British Beer and Pub Association (BBPA) said that the guidance did not provide consumers with a 'fully objective picture' and failed the 'common sense test'.

A YouGov survey commissioned by the Campaign for Real Ale (CAMRA), meanwhile, found that more than half the public 'disagree' with the guidelines, with more than 60 per cent of respondents believing that 'moderate alcohol consumption could be part of a healthy lifestyle' and over 50 per cent disagreeing with the decision to make the guidelines the same for men and women. 'If the public feels, as our figures suggest, that the guidelines are not credible and lack evidence, the danger is they will increasingly just ignore them,' said CAMRA chair Colin Valentine.

*UK chief medical officers' low risk drinking guidelines, and How to keep health risks from drinking alcohol to a low level: Government response to the public consultation at [www.gov.uk](http://www.gov.uk)*



**'If the public feels... that the guidelines are not credible and lack evidence, the danger is they will increasingly just ignore them.'**

COLIN VALENTINE



**'If there is a resurgence in new HIV infections now, the epidemic will become impossible to control.'**

MICHEL SIDIBÉ

## HEADS DOWN

**MORE THAN 330 RETAILERS** have either closed down or stopped selling NPS since the controversial Psychoactive Substances Act came into force in May, the government has announced. Nationally, 24 'head shops' have closed and a further 308 have stopped selling the substances, while 186 people have been arrested. 'It's still early days but the police enforcement approach combined with education and support services for users is helping to reduce the damage that misuse of these substances can cause in communities,' said National Police Chiefs' Council lead for psychoactive substances, Commander Simon Bray.

## HIV WARNING

**THE DECLINE IN NEW HIV INFECTIONS** in adults has stalled, says a UNAIDS report, with infection rates now rising in some regions. Eastern Europe and central Asia saw a 57 per cent increase in annual new infections between 2010 and 2015, states *The prevention gap*. Although more than half of these were among people who inject drugs, allocation of resources for prevention are still 'falling far short' of what is needed warns the agency. 'We are sounding the alarm,' said UNAIDS executive director Michel Sidibé. 'If there is a resurgence in new HIV infections now, the epidemic will become impossible to control.'

*Report at [www.unaids.org](http://www.unaids.org)*

## DUAL FAILINGS

**PEOPLE WHO MISUSE DRUGS OR ALCOHOL** and also experience mental health issues are being 'denied access to proper treatment', according to a Turning Point report. NHS services are not set up to support multiple needs and people are consequently 'falling through gaps' in care, says *Dual dilemma: the impact of living with mental health issues combined with drug and alcohol misuse*. 'So often people with overlapping mental health and substance misuse issues are labelled "hard to reach" when it's the services that are hard to access,' said Turning Point chief executive Lord Victor Adebowale.

*Report at [www.turning-point.co.uk](http://www.turning-point.co.uk)*



**'People... are labelled "hard to reach" when it's the services that are hard to access.'**

LORD VICTOR ADEBOWALE

## DARK DATA

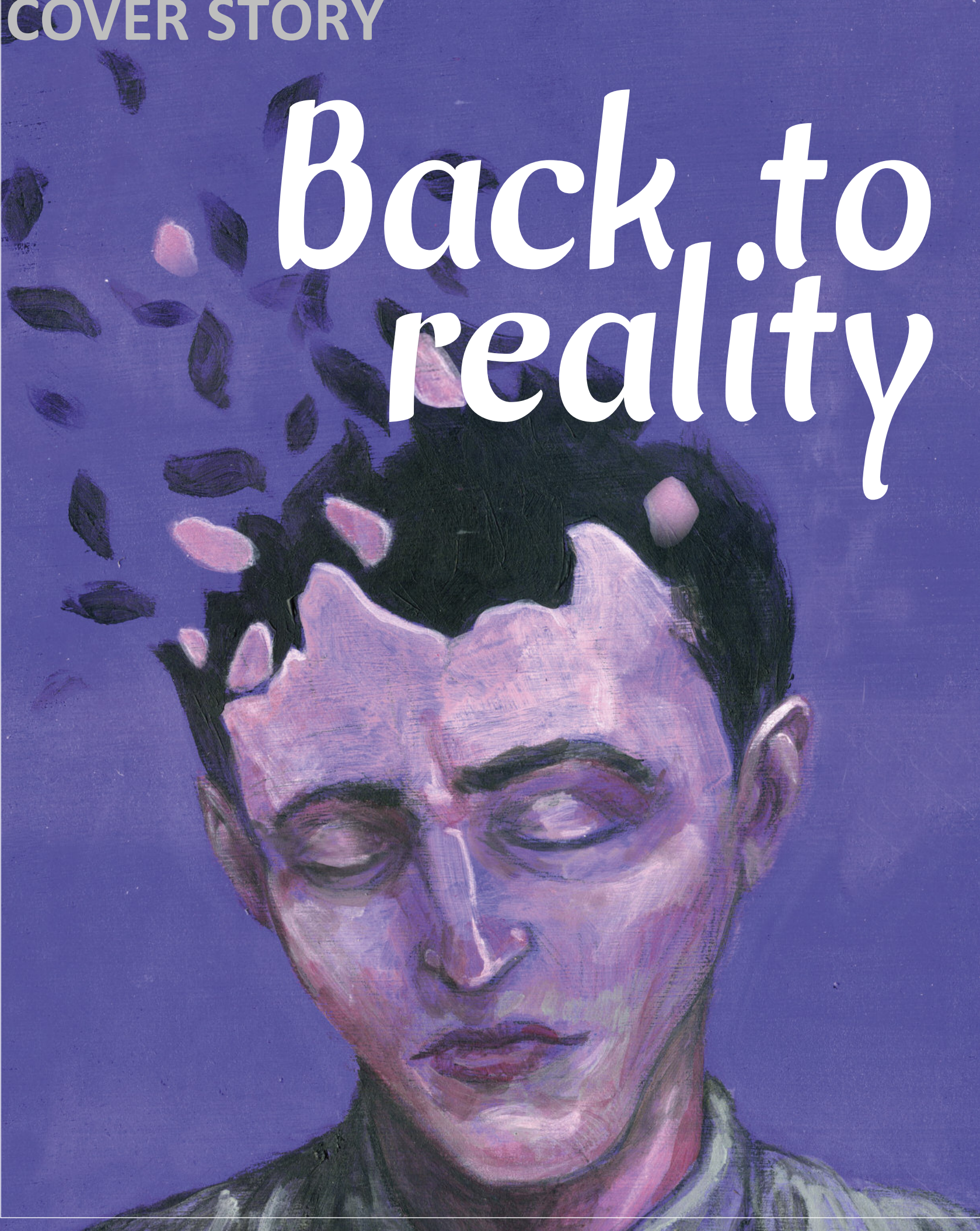
**HOSPITAL ADMISSIONS FOR DRUG POISONINGS HAVE RISEN** by more than 50 per cent in a decade, according to HSCIC figures. There were 14,280 admissions with a primary diagnosis of poisoning by illicit drugs in 2014-15, up 57 per cent on 2004-

05, says *Statistics on drug misuse: England 2016*, with 45 per cent of admissions among 16 to 34-year-olds. There were almost 75,000 admissions with a primary or secondary diagnosis of drug-related mental health and behavioural disorders, up 9 per cent on the previous year.

*Figures at [www.gov.uk](http://www.gov.uk)*

COVER STORY

# Back to reality





Korsakoff's syndrome is a severe memory disorder, associated with long-term alcohol misuse.

## Glenn Barnett shares a new model to support those affected and help them back to community living

**K**orsakoff's syndrome belongs in a spectrum of disorders categorised as alcohol-related brain damage (ARBD). It is a severe memory disorder associated with excessive, long-term alcohol misuse, and results in the loss of specific brain functions due to the lack of vitamin B1 or thiamine. Post-mortem studies suggest that Korsakoff's occurs in about 2 per cent of the population and 12.5 per cent of dependent drinkers.<sup>1</sup>

Finding community support for individuals' specific needs, especially for younger adults, is a real challenge as there is limited specialist provision available across the UK. The Arbennig Unit – part of Queen's Court Residential Service in Conwy and run by care provider Potens – was set up in 2002 to support younger adults with alcohol-acquired brain injuries within an appropriate and responsive environment.

Our aim was to provide people with Korsakoff's opportunities for choice and independence – with the focus being on what the individual could do, rather than what they could not do.

What we quickly realised was that to provide the consistent and predictable support required, we would need to develop a bespoke support model.

A trawl of available literature did not give us what we needed, so we developed the Arbennig clinical support model based on the idea that rehabilitation should aim towards a structured, alcohol-free life.<sup>2</sup> So abstinence became the cornerstone of our model.

Based on empirical observation, there is a high probability that Korsakoff's sufferers' lifestyles have been chaotic, with little, if any, of the social support networks that people would take for granted from friends and family. In response to this, Potens' support model looks at involvement of professionals, but does not underestimate the importance of family and friends – in circumstances where these relationships have either not been damaged or can be restored.

The health needs of Korsakoff's sufferers have often been compromised by poor diet. In addition we have come to understand that underlying mental health issues often become more pronounced after a period of abstinence. So we work in collaboration with a wide variety of health professionals to promote improvements and positive outcomes in both physical and mental health.

James had been a resident of Arbennig Unit since July 2015. Having faced some very personal challenges in the past, he had turned to alcohol to help him cope. This resulted in a need for support around his daily activities and the confidence to live independently in the community.

Our admission process is supported by FIM FAM. The functional independence measure (FIM) is an 18-item global measure of disability. It is used to measure disability in a wide range of conditions, with each item scored on seven ordinal levels. The functional assessment measure (FAM) specifically addresses cognitive and psychosocial functions, which are often the major limiting factors for outcomes in brain injuries.

We also use the Addenbrookes' cognitive examination (ACE), which is a brief neuropsychological assessment of cognitive functions and a development on the mini mental state examination (MMSE – the most commonly used test for cognitive function) focusing on memory.

On completion of assessments, James and the staff worked out priorities for helping to achieve his aim of moving out to independent living. Strength-based support plans were developed to complement findings and to ensure that a full, active and worthwhile programme was developed.

A lot of work was completed around abstinence and the benefits – both physically and emotionally – were reinforced in the context of James wanting to move back into the community and keep hold of a tenancy. This was only successful as we adopted a collaborative approach with specialist input from a multi-disciplinary team of professionals, including support charity CAIS.

An important goal for James was to self-medicate as this would enable him to maintain improvements to his mental and physical health. It would also keep to a minimum visits from a care team, which had been making him feel that his flat was a workplace and not his home.

James regained the confidence and skills to manage his community access. This was completed initially on a one-to-one basis with staff to build up confidence, then support was withdrawn, gradually enabling him to access the community independently.

Family connections had broken down because of his chaotic lifestyle, and he had recently separated from his wife. Staff supported James to contact his ex-wife and re-establish a relationship to the point that they would travel together to see their granddaughter. Staff then supported James to contact his son to let him know how hard he was working and how much progress he had made.

A barrier to improving James' health had been his inability to eat healthily, due to benefit problems and managing some debts that had spiraled out of control. After some work on budgeting skills and support to ensure he was on the right benefits, James was able to afford healthy meals and enjoyed cooking again.

He completely engaged with the team and worked within the support model with more commitment as progress was being made. Over the weeks, staff noticed James's confidence growing and skills were rediscovered and built on. He faced every challenge presented to him head on and with the Arbennig staff team conquered each and every one.

James moved out into a supported living tenancy in February 2016. We are confident that as a team we have equipped him with the right skills and instilled enough confidence for him to succeed in his endeavours in the future. He also now has the support of his family, whom he now sees on a very regular basis, to help him succeed.

Like Arbennig, any establishment that supports adults with Korsakoff's through a rehabilitative process needs a thorough understanding to achieve the progress experienced by James: Korsakoff patients are capable of new learning, particularly if they live in a calm and well structured environment and if new information is cued.<sup>3</sup>

This forms a key part of Potens' model for staff supporting residents like James, helping him restore and relearn daily living skills by providing meaningful activities.

**Glenn Barnett is area manager at Potens, [www.potens-uk.com](http://www.potens-uk.com)**

**For further information on Korsakoff's or this model, contact him on 07914 607745**

(1) Alcohol Concern factsheet updated 2001

(2) Jacques A., Anderson K., (2002) A Survey on assessment, management and service provision for people with Korsakoff's syndrome and other chronic ARBD in Scotland. Dementia Services Development Centre. Stirling

(3) The Korsakoff syndrome: clinical aspects, psychology and treatment. Alcohol and Alcoholism vol 44 No2 pp 148-154 2009

# I'm worth...

Drug and alcohol use can place individuals at risk of a range of health problems. Users who share drug-injecting equipment may be exposed to blood-borne viruses, including hepatitis C. The advances in treatment for hepatitis C mean they work better, have shorter treatment times and are easier on the body, which means cure may be more attainable for those also battling addiction. Evidence shows the relationship between addressing healthcare needs, such as hepatitis, and progress in drug recovery.<sup>1</sup>

## HEPATITIS C AND ME: HOW BEING CURED CHANGED MY OUTLOOK

**Kevin Stow, an ex-drug user and previous hepatitis C sufferer shares his experiences and talks about how being cleared of hepatitis C helped give him the momentum to overcome his drug addiction. Kevin is an ambassador for the recently launched *I'm Worth...* campaign, which aims to address the stigma that many people with hepatitis C face, encouraging and empowering people living with hepatitis C to access care and services no matter how they were infected.**



**'When my hepatitis C was cured, it gave me the momentum to really go for it and become drug free.'**

KEVIN STOW

no point trying to overcome hepatitis C. To me, my life was already over. I felt that I had no other choice, other than to keep using. It all felt too much for me to handle.

'The turning point for me was when a team from the local hospital hepatology unit came into the drugs clinic and I started speaking to more people about my hepatitis C. When I was ready to consider treatment and drug recovery, the support I received was fantastic.

My key workers played a very important role in helping me understand hepatitis C treatment options and some of the consequences of living with untreated hepatitis C. I believe this information and support is what saved my life.

'After treatment, my hepatitis C was cured and I felt like I had one less burden in my life. Getting cured was an important step in my recovery journey. I felt beating hepatitis C gave me the motivation to face other challenges, including becoming drug free.

'Being cured of hepatitis C completely changed my outlook. When I stopped using and was in drug recovery, I became a volunteer hepatitis peer mentor. Now I have a full-time job in Southampton drugs clinic. I'm

very passionate about educating people about the importance of considering hepatitis C treatment. I know what a difference it has made in my life. I hope that if I can play a role in helping someone else know more, they can take the right steps to try and clear hepatitis C.

'It doesn't matter how you got hepatitis C, no one deserves to live with a potentially life threatening disease.'

**Kevin Stow is an ambassador of the *I'm Worth...* campaign. You can view his story, alongside others at [imworth.co.uk/ambassadors](http://imworth.co.uk/ambassadors)**

- 1 PHE. *Improving access to, and completion of, hepatitis C treatment.* 2015
- 2 PHE. *Hepatitis C in the UK. 2015/2014*
- 3 Hawkes, N. *Confronting the silent epidemic: a critical review of hepatitis C management in the UK.* [www.hepctrust.org.uk/Resources/HepC%20New/Hep%20C%20Resources/Reports/HALO\\_Media\\_Report\\_FINAL.pdf](http://www.hepctrust.org.uk/Resources/HepC%20New/Hep%20C%20Resources/Reports/HALO_Media_Report_FINAL.pdf) (Last accessed August 2016)

The *I'm Worth...* campaign is a disease awareness programme, that has been developed and paid for by Gilead Sciences Ltd, a science-based pharmaceutical company. Content development has been supported by input from numerous patient groups with an interest in hepatitis C in the UK.

August 2016, HCV/UK/16-08/CI/2138

Despite effective medicines that can cure the majority of people with hepatitis C now available on the NHS, most people diagnosed with hepatitis C in England remain untreated – one of the lowest treatment rates among northern European countries.<sup>2,3</sup>

Choosing whether or not to start treatment is

not always an easy decision. Drug support services can play a vital role in providing current and previous drug users with hepatitis C information and support, educating clients that hepatitis C is treatable and, in the majority of patients, can be cured, can help them make important decisions about their health.

For more information on the campaign and to access materials designed to support people living with hepatitis C please visit [www.imworth.co.uk](http://www.imworth.co.uk)





## PEER-LED PROGRESS



Since founding Dear Albert four years ago, **Jon Roberts** has focused on developing recovery communities through peer-led interventions. He shares the latest exciting developments

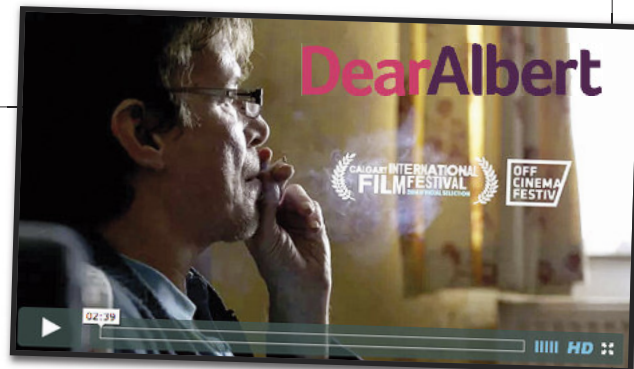
IT'S TWO YEARS SINCE THE RECOVERY DOCUMENTARY *DEAR ALBERT* PREMIERED AT THE INTERNATIONAL FILM FESTIVAL IN CALGARY. A lot's happened since then. Our peer-led programme 'You do the MAFs' (Mutual Aid Facilitation Services) has been further developed and is currently helping people in Leicestershire address substance misuse.

Today we have ambitions to help many more. The plan is to make our services available as an 'off the shelf package' so other communities benefit. Talk of devolving services to those that have been nearer the problem isn't new. What's new is that Dear Albert is realising what the sustainable model looks like.

It's a model that provides recovery communities directly with earned income – services purchased by commissioners, main providers and others successfully delivered by recovery community members. So the mechanism is born to develop what I call the 'purple pound' by dispersing income to those in recovery. And for those that consider recovery communities a myth, let me tell you – I live in one.

But it's mainly about partnerships. It's about collaborative enterprise that works in unison with bigger providers and community assets to create longer-term solutions. Part of our start-up funding and support came through the University of Leicester's Enterprise Inc2 project and the Leicester Recovery Partnership's innovation fund. Now we're delivering group work in HMP Leicester and also in the community via West Leicestershire clinical commissioning group. Our latest partnership is with Turning Point.

The exciting news is we've had a six-month evaluation of 'You do the MAFs' published in the *Journal of Groups in Addiction and Recovery*.



The findings are very positive, highlighting the benefits of our structured and intensive pathway into mutual aid. Bridging this gap through better formal peer-led mechanisms like 'You do the MAFs' suggests more service users attending mutual aid and that they can continue to increase aspects of their recovery as a consequence.

The fact that we can use this intervention to support our own recovery communities is the icing on the cake. It's great to see that the work we do here is starting to be recognised elsewhere and that we are able to contribute to the evidence base. We use interventions such as peer-led ACT and the *Dear Albert* film and have refined our messaging to create a whole package that gets the message across that people do recover, and helps identify the best route for each individual.

Securing the structure by which other communities can start generating their own income by using 'You do the MAFs' is Dear Albert's next step. The basic model – Independent peer-led facilitation into existing community assets – is already in place.

**Jon Roberts is director of Dear Albert, [www.dearalbert.co.uk](http://www.dearalbert.co.uk)**

### RESOURCES CORNER



## The human touch

Looking for insight into addiction treatment, **George Allan** finds evidence and empathy in the work of Bill Miller

IN THE 1970S, A NUMBER OF PSYCHOLOGISTS EMERGED TO CHALLENGE THE PARADIGM THAT SUBSTANCE PROBLEMS ARE A RESULT OF AN INNATE DISEASE CONDITION. Major figures such as Alan Marlatt, the Sobells and Nick Heather demonstrated that problems could be understood, to a significant degree, as the product of faulty learning; this led to the development of a range of innovative interventions based on behavioural theories. Bill Miller was one of these revolutionaries. In a fascinating interview available free online, William White explores with Miller the extent of his work and his concerns.

Bill Miller is, of course, best known as the father of motivational interviewing but his contribution is much wider than this, as the interview demonstrates. Miller's curiosity has led him to research such diverse areas as what makes some people more effective counsellors than others, the influence of AA on recovery outcomes, motivation, spirituality and recovery, transformational change experiences and community reinforcement approaches. His work is characterised by an insistence on basing 'treatments' on the evidence provided by rigorous

## Bill Miller on relapse: 'In good recovery... episodes of symptoms become shorter, less severe and more widely spaced. Perfection is the exception.'

research, grounded in a profound humanity as this sample of quotes from the interview shows:

- *On empathy: 'It is a respectful, hopeful, engaged kind of listening that brings out the best in people.'*
- *On the concept of rock bottom and motivation: 'It's not that people need to suffer severely; it's that they need to decide.'*
- *On motivational interviewing: 'I'm not sure it's a "technology" as much as a way of being with people.'*
- *On relapse: 'In good recovery... episodes of symptoms become shorter, less severe and more widely spaced. Perfection is the exception.'*

This is the sort of article which, read over the lunchtime sandwich, can give hard-pressed practitioners inspiration for the afternoon to come. For those who have experienced problems themselves, it provides insights into the best that interventions can provide.

Let's leave the final, and optimistic, note to Miller himself: 'The good news in addiction treatment is that we now have a menu of evidence-based alternatives to try. If one thing is not working, try something else, or a combination of approaches.'

The interview is available at <http://bit.ly/2c3WwZM>

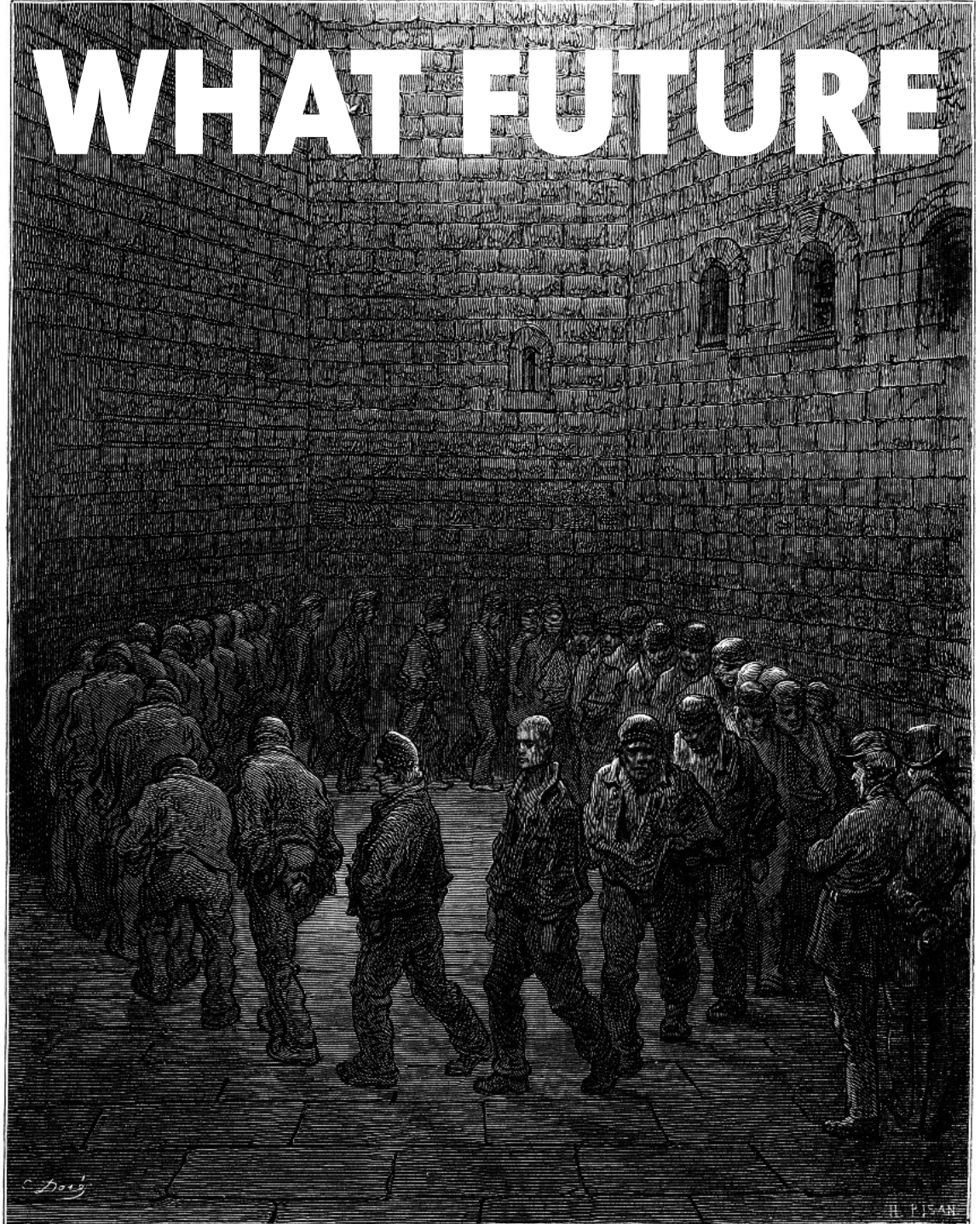
**George Allan is chair of Scottish Drugs Forum. He is the author of *Working with Substance Users: a Guide to Effective Interventions* (2014; Palgrave).**

# PRISON REFORM



With NPS problems making regular headlines and a general consensus that the system isn't working, the UK's prisons are in bad shape.

**David Gilliver** reports on a major project that could help create something new



**E**arlier this year the government announced 'the biggest shake up of prisons since the Victorian times', with plans for six major new 'reform prisons' and unprecedented freedoms for their governors with regard to budgets, education, rehabilitation services and more (*DDN*, June, pages 5 and 7).

That seems a long time ago now. David Cameron was still prime minister, the UK hadn't voted to leave the EU, and Michael Gove, chief architect of the reforms, was justice secretary rather than a back bencher. Around the same time, however, RSA launched its own major project to look at how prisons could become fit for purpose for the 21st century and ensure 'lasting social reintegration' for ex-offenders.

'At present, when nearly half of those in prison go on to reoffend within a year, we cannot say our criminal justice system is working,' wrote Gove in his introduction to the project's scoping paper, *The future prison*. 'When prisoners are prepared to risk their lives taking new psychoactive substances as an antidote to boredom, we cannot say our programme of purposeful activities is working.'

By the end of the year the aim is that the project will have come up with a

blueprint for a future prison that places the 'challenge of rehabilitation' at the centre, and will also have identified what the government needs to do to ensure the right legislative framework for funding, policy and governance is in place to achieve it.

'We know what's wrong – what there hasn't been is "how do you put it right",' says chair of the project's advisory group, and former prison governor, John Podmore. 'A lot of the debate is still around "you can't do anything until you reduce the prison population and get more resources", and we shouldn't stop fighting for that, but you have to deal with the problems we have now and start developing a strategy for longer-term improvement. This is about the long-term strategic issues that hadn't really been considered in a holistic way.'

It also aims to address the dislocation between theory and frontline experience and, ultimately, between 'prisons and the wider community'. To this end, it points out that in most countries prisons are run by the state, or, increasingly, by private companies, while no one has so far explored a 'third way' – not for profit prisons run by the communities they are 'there to serve'. How much of an appetite for that model is there likely to be, though?



# FOR OUR PRISONS?

'The key thing is that without a focus on purpose you end up having technical discussions about the public sector, the private sector, or the not for profit sector,' says project lead Rachel O'Brien, 'rather than saying "if you're judged, incentivised, measured on this, it matters less who the provider is". Things are so difficult at the moment that what you're getting is this strange mix of top-down control with very little accountability, so it's kind of the worst of both worlds.'

The project focuses on core areas like leadership, education, employment, health, risk, rehabilitation, devolution and autonomy. The latter is central, explains O'Brien. 'So rehabilitation first, but how does greater autonomy support that outcome? A key thing would be much more emphasis on being outward looking, as well as partnership, and that has great implications not just for the governor role but the relationship between the prison and criminal justice boards.'

One area where the system has been falling down is that prison officers, doctors, nurses and teaching staff are simply not having prolonged contact with prisoners, or getting to know them in any meaningful way. 'Everybody reading *DDN* knows that the essence of successful drug and alcohol treatment is the case worker,' says Podmore. 'You can have all the treatment protocols in the world, all the contractual requirements, but at the end of the day success for the client is someone who gets to know them, works with them, gains their trust, addresses their issues and is central to their rehabilitation.'

On that subject, the scoping paper makes the point that while reoffending rates provide 'seductive hard data', the concept of rehabilitation is harder to grasp. Is that a barrier that can be easily overcome when it comes to meaningful reform? 'I think it's getting there,' says O'Brien. 'A lot of our work actually draws on the recovery area, so when somebody says to me, "It is nebulous, we can't measure it", I say, "Well, no more so than concepts like recovery capital, and more so than wellbeing". A lot of the indicators you would use would be very similar. I think the biggest risk is that we chase the holy grail of reoffending.'

It's partly about talking about community safety, risk and rehabilitation 'in the same breath', she explains. 'Sometimes it felt like these things are put in different corners, as if they're a choice, when the evidence is that they're very closely aligned. We've had a very risk-averse, security-driven approach rather than a rehabilitative approach.'

'It's the whole issue of what you measure and how you measure it,' adds Podmore. 'It's a very difficult thing, and the drug and alcohol field has had this for years with abstinence and recovery. The National Offender Management Service's (NOMS) primary measure of drug use in prisons is mandatory drug testing, and in the last annual report it went down. Therefore there isn't a drug problem in prison, because the main measure is showing a reduction. We know that's palpable nonsense, so why are we still doing it?'

The one thing that's not measured is leadership and management, he argues, and when it comes to the issue of devolution of justice, there's a compelling case for splitting the prison service up. 'There's 85,000 people in prison, and maybe 25 or 30,000 really need prison in the traditional sense. How many of the 85,000 are we afraid of, and how many are we mad at? Locking people up is very easy to do – getting people out so they don't come back is the tricky bit, and that's where we're failing miserably. So I'd have a kind of federal estate for the long-termers and terrorism and so on – a traditional, centralised system – and then a devolved, local, community prison estate which is looking at people who are going in and out. That will be governors with autonomy reporting to local boards, with devolved, integrated justice.'

So how much of an impact is the new government likely to have on the reforms set out in the Queen's Speech, or is it too early to say? 'All I can go on is what [justice secretary] Liz Truss has said to the press, which is that she's going to push ahead and push ahead quickly,' he says. 'The message seems to be that, OK, there's been a change of people but the policies are in place. That's not to say there aren't all sorts of imponderables around budgets and finance, and things you can't predict. But when you look at the levels of violence and assault and illicit drug use, then something's got to be done, and done quickly.'

On the subject of drugs, when it comes to the much-discussed impact of NPS, the paper argues it's inextricable from the question of prisoners' needs. 'It goes

'My plea to the drug and alcohol network out there is be knocking on the door and demanding more involvement in these issues. The people who know best how to deal with these problems are not being included.'

JOHN PODMORE

back to culture, really,' says O'Brien. 'There's no part of the project that doesn't see on a daily basis the acute impact it's having on everybody, but however much we get the testing right, or drones or security, we're not going to change the demand side. All the evidence is that a key part of it is when people are doing nothing.'

It also means that much more effort needs to be put into awareness-raising and education, both on the outside and as people come into prison, rather than 'waiting until it's too late', she argues. 'It's not just in-custody education, it's a broader community approach. It's about demand, and the inability to adapt to new challenges, which again goes back partly to autonomy. You need the system to support you and share the best evidence of what does work, but governors need to have the flexibility to respond to issues that change very rapidly.'

A key failing is that drug and alcohol service providers simply aren't being involved in the debate, states Podmore. 'The response is bring in drug dogs, or chop down trees around the perimeter to stop stuff being thrown in. The people in NOMS who've been responsible for the strategic approach to drug problems in prison have never recruited, or sought to recruit, the sort of high quality people I've come into contact with in the drug and alcohol field. Whoever's dealing with the NPS issue is going to be looking at it from a security perspective rather than a treatment perspective. Yes, you've got to stop NPS coming in, but you've also got to stop prisoners wanting them, and it's hugely complicated – it's about education, treatment, the wider regime. My plea to the drug and alcohol network out there is be knocking on the door and demanding more involvement in these issues. The people who know best how to deal with these problems are not being included.'

'I know a lot of the organisations reading *DDN* are being beaten over the head about winning, retaining and competing for contracts. I know the pain of all that. But I'd like the sector to be saying, "we've got much more to offer than you've realised and you should be reaching out to us much more". The drug and alcohol sector understands the problems of people leading chaotic lives, and families, and illicit drug use. It's not about the setting, it's people with complex needs, and the sector's been handling that pretty damn well for years.'

<https://www.thersa.org/action-and-research/rsa-projects/public-services-and-communities-folder/future-prison>

# Reaching out

How do we find and treat the ‘hidden cohort’ of patients addicted to opioid painkillers? In the second of a three-part series, **DDN** reports

‘People who are addicted to painkillers are a really complex group,’ says Jon Royle, chief executive of the Bridge Project. ‘You’ve got people who are prescribed painkillers and who are also using illicit drugs and have complex addiction issues. And you’ve got other people who were prescribed them to manage pain legitimately, so where the pain relief is required and where it has become an actual addiction problem is no longer clear cut.’

Among the patient group are those with complex emotional, psychological problems, who are taking anything to make themselves better, he explains. ‘So there are a lot of issues to work with when you get into this cohort.’

At the Bridge Project, based in Bradford, staff had experienced success in running a benzodiazepine withdrawal service for the past seven years, targeting patients in primary health care and GP practices.

‘Doing that kind of work in primary care, we were also coming across a great deal of patients addicted to prescribed painkillers as well,’ says Royle. As with the benzos, ‘these patients are never going to roll up at an addiction treatment service on the high street – but that doesn’t mean that there’s not tens of thousands of them out there, people who’d say “I’ve never been near an illegal drug in my life”.’

So they decided to develop a model along similar lines to the benzodiazepine scheme, going into GP practices with the highest levels of prescribing and using the Opioid Risk Assessment Tool (ORAT) – which sits alongside the patient record system, Emis – to screen patients. They then worked with GPs to review the patients’ prescribing and liaised with specialist doctors and addiction practitioners to offer treatment, detoxification and support such as cognitive behavioural therapy (CBT).

The response has been ‘really good, with far better outcomes than with opiate users,’ says Royle – success he attributes to planting the service within primary care.

‘The problem occurred in primary care and it’s best to manage it in primary care, with the support of the GP,’ he says. ‘You get better compliance with



treatment and much better engagement. I don't think many of the patients that we're talking about would want to work with you if you tried to transfer their care into community drug treatment settings, although there are a small number that you do have to transfer into the specialist services – those that are already using illicit drugs and have quite entrenched addictions.'

A characteristic of this group is their high level of motivation to change. 'They've got insight that the medication is not helping them anymore, and that it's become a problem in itself,' he says, adding: 'That's not to say that they don't need quite a bit of support and counselling as well when they come off these medications, to deal with the underlying issues.'

So what about the hard-pressed GPs – were they difficult to engage?

Many GPs have inherited these patients, says Royle. 'A lot of them have taken their medication for so long that it would be difficult to say who actually started them on it – they've seen lots of different clinicians and professionals over the years.'

'Obviously it's an extremely difficult issue for a GP to handle on their own if they've got a patient who's been physically dependent on opiates for years and years and is not actually causing a fuss, just turning up and getting a repeat prescription. How can they easily address it when they've got ten minutes for an appointment?

'So we're often greeted with a lot of willingness and a sense of relief by GPs that somebody's actually going to come in and help them.'

Bradford is fortunate in having commissioners who understand the issue, he says. The clinical commissioning group (CCG) is very supportive of the scheme and has a clear financial incentive to see it work – 'in one area, if they could just get down to the national average level of prescribing of the top most common opiate based painkillers, they would save £1.4m,' he says.

But it's not easy in a climate of tightening budgets and increasing caseloads.

'You've got to go out there and find the patients in primary care and be proactive,' says Royle. 'And that does require dedicated investment – it's no good just saying we've

created a treatment system and if they come to us we will treat them. Commissioners will have to be very specific if they want to see any inroads into this patient cohort, and that's a difficult challenge for them.'

**'We're often greeted with a lot of willingness and a sense of relief by GPs that somebody's actually going to come in and help them.'**

A public health programme lead for substance misuse at South Gloucester Council, Matt Wills also uncovered a problem with prescribed opiate use in his area – 'a massive spike as big as the Shard in London' that demanded attention.

He soon recognised the difficulties in reaching this cohort, hidden behind the legitimacy of the doctor's prescription, 'sat comfortably and completely addicted to opiates'.

'These people can be quite affronted when you say "you may have a substance misuse problem",' he says. 'They would say "well I'm not an addict am I, because a doctor's prescribed it. How can I be misusing if I'm using my script?" Predominantly these are people that are working, are integrated into society, and not causing a problem. They're not showing up in A&E, they're not showing up in police cells. But inevitably their addiction is going to show itself somewhere in the health system.'

Wills realised he needed statistics to inform a strategy. 'So we drew on global, regional and local data, we grabbed whatever we could and we wrote an opiate analgesic profile – that was the start of a plan,' he says. 'And it was a very contentious paper because what I had to do was say "we've got an addiction problem with prescribed meds, but we're not blaming the GPs because they're under immense pressure". Because the minute I disengage the GPs, we're in trouble.'

'So I had to be very careful about saying "we understand the seven-minute consultation. We understand the seven-day-a-week NHS". You have to do it in a way that the GPs want to have these conversations. What we don't want to do is say to GPs, "here's another

problem". We want to say "you have a powerful voice.

If you're willing to start the conversation and work with us, we will wrap services around you"'

The approach worked. 'Two GPs that work for the DAT said, "do you know what? We do overprescribe and

we think we could do better so we'll be happy to be part of your pilot". To get two GPs on board, willing to take part, was probably the biggest key in terms of partnership,' he says.

'This is a GP-led intervention, where the GP will have the relationship with their patient and lead them through their care, with the support of shared care workers, consultants and pain meds,' he emphasises. 'Because the minute we start to lose that local GP-led intervention, people start to lose trust.'

The fact that South Gloucestershire is in the process of moving substance misuse into primary care will strengthen the initiative, he adds, 'as our new cohort don't want to sit in a drug centre.'

Asking Public Health England (PHE) to endorse the project initially proved more difficult, as they were reluctant to support it until it was successful. Wills was frustrated – 'sometimes you've got to innovate, you've got to take a risk'.

But endorsement of the local 'really strong' joint commissioning group brought key partners on board, including the police and crime commissioner, clinical commissioning group, GPs and the police. It secured the £50,000 of local public health funding he needed, on the understanding that 'at the end of the pilot this may be of interest to everyone and more people may need to invest'.

Using the ORAT data collection tool, Wills and his team extracted eight cohorts of patient that were receiving high levels of prescriptions.

'So we've set up assessment tools, we've got the structure set up with consultants and pain clinics – we've set up the model and are starting to look at people who are maybe using too many opiate painkillers and could be using less. We're looking at how we can reduce their need for primary clinical interventions and how we can release the burden on GP surgeries and on medication costs.'

And while the clinical cost is important, it's the wider health outcomes that really matter, he says, which has prompted them to start developing a tool similar to the Treatment Outcomes Profile (TOP), to show the patient's direction of travel.

'You can track the engagement, you can track the discharge rates, you can track clinical interventions, you can track the GPs,' says Wills. 'But what we're also doing alongside it, is tracking the more holistic approach – how the patient's feeling.'

For all the progress, Wills sees plenty more challenges ahead – not least in reaching the children and grandchildren enjoying a plentiful supply of pure opiates in grandma's bathroom cabinet. But he is confident that upskilling GPs is a valuable first step.

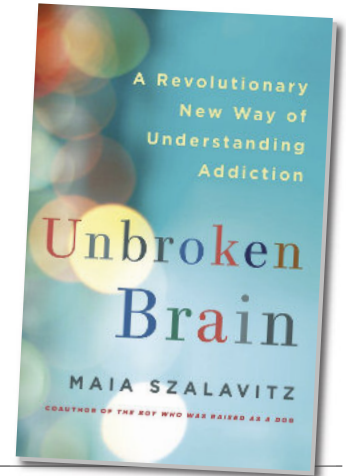
'We want them to be able to help their patients to think when they look in their medicine cabinet, "do you know what? I seem to have quite a high stash here of pain meds here. Do I need help?"'

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

*This article has been produced with support from Indivior, which has not influenced the content in any way. ORAT is a screening tool which is provided by Indivior as a MEGS (Medical and Educational Goods and Services).*

# The Third Way

At a recent Volte Face/DDN event in London, Johann Hari interviewed Maia Szalavitz about her newly published thoughts on addiction. This is an extract from their conversation



First Szalavitz described her own experiences, experimenting with psychedelics, then becoming addicted to cocaine and heroin.



**Johann Hari:** 'Usually when someone tells this publicly, they say "Society tells me what a disgusting wicked person I was – and then I discovered in fact I had a disease." But part of the movement we're part of is arguing that actually, there's a third option, which is that you're neither evil nor diseased. Can you talk about what the third option is?'



**Maia Szalavitz:** 'When I got into recovery, the disease model was the only thing that was presented as the alternative to the sin model. And so I grabbed onto it. But one of the things that always bothered me was, everybody tells me it's a chronic, progressive disease, and it's

destroying your brain. That makes me think of something like Alzheimer's – and you can't get into recovery from Alzheimer's, sadly. Also it's the case that research shows that people are more likely to get into recovery the older they get. So if it was a chronic, progressive disease, that should be the opposite.

If you look at gambling addiction, and you look at sex addiction, there's no chemical involved. There is no chemical changing your brain, and causing you to behave this way.

And if this can happen with no chemical, then the brain damage that people are talking about with chemical addiction must not be necessary to addiction happening. And so I began to realise that – and this is not original to me; the scientists have been saying this forever – that addiction's a learning disorder. It's defined as compulsive behaviour that occurs, despite negative consequences.

So that's also what happens in these other processes. And it also means that when you are trying to kick addiction, it's more like trying to get over the worst break up of your life than it is like having a serious disease – although in some instances, you can

certainly have severe physical withdrawals and those kinds of things.

But those things aren't the essence of a problem. I hear so many people talking about opioid addiction these days, and everybody's like, "Oh well, they just are avoiding withdrawal – you just can't bear withdrawal, it's the worst thing ever." I went through it like six times. It does suck. But it is not bad, like if anybody's ever had any kind of serious illness. It is not anything compared to some of those things.

And it also isn't the problem. Because every time I stopped using long enough to lose my physical dependence, I was fine for a couple of weeks – and it wasn't that I was sick that made me want to get high. I wanted to get high, because I thought, "Oh, I can just do this on weekends now."

So it was the psychology that was driving the problem, and not the physiology.'

*Unbroken Brain by Maia Szalavitz, published 13 October, St Martin's Press.*

*Chasing the Scream by Johann Hari, published January 2016, Bloomsbury.*

## MEDIA SAVVY

The news, and the skews, in the national media



**CHEERS, THERESA.** The PM is already showing the sort of common sense her predecessor frequently lacked. The slapdown for top doc Dame Sally Davies over alcohol guidelines is significant. May's move shows a government intent on treating us like grown-ups, not like children who need to be nannied. Her hysterical

warning that ANY amount of alcohol is bad for you was simply ridiculous... As the Brexit vote showed, we Brits like to make up our own minds – regardless of a small, closed Westminster cabal hectoring us.

*Sun on Sunday editorial, 21 August*

**IF A TRENDY CHARITY ANNOUNCED** that it was holding seminars for burglars, to show them how to avoid being hurt in the course of breaking into our homes, you wouldn't expect the police to approve. They may not care all that much about crime these days, but they'd have to put a stop to it. Yet when a trendy charity offered to test illegal drugs for 'quality' at a music festival in Cambridgeshire, the

local police gave their blessing. The 'tests' duly went ahead, and hundreds of squalid, selfish people went unpunished for blatant breaches of criminal law. All that users of illegal drugs need to know about quality is that they are dangerous. That's why it is illegal to possess them.

*Peter Hitchens, Mail on Sunday, 31 July*

**DEBATES ABOUT HARM REDUCTION** always follow the same pattern. Hysterical fears are confidently asserted as if proven beyond doubt while potential benefits, often based on considerable research and experience, are dismissed or ignored.

*Alex Wodak, Guardian, 11 August*

**IF WE REALLY WANT TO TREAT ADDICTION** like the medical problem it so clearly is, we can't use the criminal

justice system to arrest people for showing symptoms of it. If you want to fight stigma, you've got to first fight criminalisation and reform the coercive and demeaning addiction treatment system that has been warped by it.

*Maia Szalavitz, Guardian, 5 July*

**SEVERAL STUDIES HAVE SHOWN** that a belief in the disease concept of addiction increases the probability of relapse. And that shouldn't be surprising. If you think you have a chronic disease, how hard are you going to work to get better? If we can acknowledge that addiction is like a disease in some ways and very much unlike a disease in other ways, maybe we can stop trying to label it and pay more attention to the best means for overcoming it.

*Marc Lewis, Observer, 24 July*

# MORAL FAILURE

When will we start listening to the evidence, asks **Prof David Nutt**

## 'WHAT ARE THE PROSPECTS FOR AN EVIDENCE-BASED DRUGS POLICY?'

Prof David Nutt was asked by the Drugs, Alcohol and Justice Cross-Party Parliamentary Group, at their latest meeting. Prof Nutt recalled his nine years' experience as chair of the ACMD.

'We developed a rational scale against which drugs could be assessed,' he said. 'It had been done in an arbitrary fashion and we tried to make it more scientific.'

But the problem with that approach was that it showed no relationship between the harms of drugs and the Misuse of Drugs Act.

'It showed what we suspected, that the act is arbitrary,' he said. 'It created a lot of consternation – and an irreconcilable difference between me and the home secretary, which led to me being sacked.'

So where next? Over the past three years he had been working with Norwegian scientists on a new analysis.

'It turns out there are 27 social variables that are relevant,' he said, and had applied these to three drugs – alcohol, cannabis and heroin – in different scenarios, from complete prohibition to a free market, including a very regulated market as Sweden had done with alcohol.

His conclusion was 'very clear for all – that state regulation is the least harmful and provides the most benefits for society'.

The research would be published during the next

few months, following peer review, and would 'hopefully provide much more debate going forward'.

Answering questions from the group, Nutt commented that the Psychoactive Substances Act was 'the worse piece of moral legislation since 1559. It constrains moral behaviour; I'm amazed there hasn't been an outcry from scientists and parliamentarians.'

The act had been driven by pressure groups and was utterly wrong in principle, he said, adding 'no other country in the world has banned drugs that are harmless.'

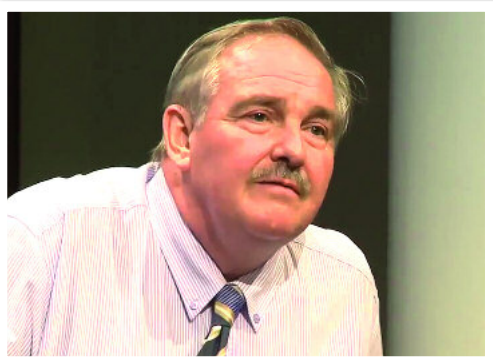
Furthermore, we had 'opened up a Pandora's Box by being terrified of cannabis', creating synthetic cannabinoids – an example of how prohibition had made things so much worse.

'I'm a scientist and a pharmacologist – we have to understand the value of drugs,' he said. 'I object to the Psychoactive Substances Act's stance that all drugs are bad, whatever they do for you. The law in itself is never a solution.'

Asked how we should use this intelligence to inform future ways of working, Nutt replied that we should target areas of greatest vulnerability, adding, 'Should anyone be in prison for possession? There's no proper debate between the prison system and government and we're destroying the lives of prisoners and staff. It's a moralistic approach to policy.'

His key message to the meeting, he concluded, was that we should have evidence-based drug policy.

'The ACMD is becoming less influential,' he said. 'We have a lot of evidence and we should listen to it.'



'We have opened a Pandora's Box by being terrified of cannabis...'

# LET'S CONNECT!

HAVE YOUR SAY BY COMMENTING ON OUR WEBSITE, FACEBOOK PAGE AND TWEETING US

Powerful testimony – Behind Closed Doors  
*@populitherapy*

Trauma in childhood considerably increases the risk of misusing drugs and/or alcohol  
*@FDNforChange*

The cost of human lives means little these days, our most vulnerable are under constant attack #one2many #WeRise  
*@drugactivist*

Definitely time to #focus – the hidden human cost of #painkilleraddiction  
*@cathrynkemp*

Stigma: Hepatitis C and drug misuse. This is a good article! I hope to read more updates from you regarding #Hepatitis  
*@ADRL Foundation*

Latest Drink and Drugs News – full of interesting articles and comment  
*@EmpManPaul*

Are we staffing services on the cheap by replacing qualified specialists with 'experts by experience'? *DDN Facebook page*

Yes... most people in recovery want to give something back, to celebrate their recovery. Services are abusing this goodwill getting people in recovery to work free for them, using people who are very vulnerable.  
*Alan Heselden*



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[www.drinkanddrugsnews.com](http://www.drinkanddrugsnews.com)

# Pole to pole



Is harm reduction the primary goal, or acceptable only in the service of eliminating drug use?

**Mike Ashton** examines two very different sets of beliefs





‘Drugs are an evil, and with evil you can’t give way or compromise.’ For Pope Francis, harm reduction in the form of prescribing substitute drugs is just such a compromise: ‘drugs are not defeated with drugs!... Substitutive drugs... are not a sufficient therapy but a veiled way of surrendering to the phenomenon.’ His words derive from a view of drug use as either inherently wrong, or so inevitably and extremely damaging that ‘no use’ is the only justifiable aim.

More temperate variants see harm reduction aims and services as permissible, but only as steps towards stopping drug use altogether. Others elevate harm reduction to an overriding objective which should never be sacrificed to an anti-drugs agenda. Between these poles UK policy has shifted, driven by the threat of HIV from its default anti-drugs base towards the harm-reduction pole.

When in the 1980s harm reduction emerged in Britain, what it was for was clear: to stop the spread of HIV among injectors, and even more so from injectors to the rest of the population. Sometimes reluctantly, its proponents accepted that prioritising this objective meant de-prioritising others, including treatment of addiction and achieving abstinence.

The turning point came in 1986 in the report of a committee set up by Scotland’s chief medical officer. Using the new test for HIV, in 1985 an Edinburgh GP discovered that half his injecting patients were infected. Facing this frightening challenge was a committee drawn largely from outside the drugs field, led by Brian McClelland from Edinburgh’s blood transfusion service.

Looking through the eyes of infection control specialists, they relegated to side issues reservations deriving from treatment philosophies focused on abstinence. For them, saving lives was the name of the game. Since ‘infection with HIV poses a much greater threat to... life... than the misuse of drugs,’ they straightforwardly concluded: ‘On balance, the prevention of spread should take priority over any perceived risk of increased drug misuse.’

## ‘Peacemakers try to gloss over the divides with, “We are all in the same game in the end, aren’t we?”’

What that meant was that injectors who won’t stop must be given clean injecting equipment, and that maintenance prescribing was a way to reduce injecting and maintain contact with injectors, not primarily a step towards detoxification and abstinence. Even enforcement was to be subjugated to the anti-HIV imperative: ‘Police policies in relation to individual drug misusers should be reviewed to ensure so far as possible that they do not prejudice the infection control measures recommended.’

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The following year McClelland’s report was cited when the UK’s Conservative government announced pilot needle exchanges to test if they could combat the deadly infection. Also in 1987, harm reduction emerged as a coherent philosophy, not just an emergency response to HIV. It was ‘high time for harm reduction’, argued Russell Newcombe in *Druglink* magazine. Rather than a ‘deviation’ to be rectified, ‘In many cases, even “dependent” drug use can be reconstrued as just another example of the basic human desire to repeat pleasurable activities.’ Across drug policy, ‘controlled use (rational choice, care and moderation)’ would displace the focus on abstinence.

In 1988 government’s official drug policy advisers echoed McClelland, asserting that ‘The spread of HIV is a greater danger to individual public health than drug misuse.’ Though abstinence remained the ‘ultimate goal’, for the Advisory Council on the Misuse of Drugs, ‘services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans’. They urged that ‘The different goals for drug misusers must not be seen as in competition’, but in fact they were. HIV could only be curbed by accepting drug use rather than primarily trying to stop it.

Hedged about as it was, at first this reversal of priorities from tackling illegal drug use to tackling HIV was not fully embraced by government. But by 1989, on the streets of England a government campaign poster forefronted the risks of sharing needles. Only the small print sought to reduce injecting, miles away from the ‘Heroin screws you up’ campaign of a few years before.

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By 2012 policy had definitively reversed back. The UK government’s ‘roadmap’ to recovery-oriented treatment subjugated ‘all our work on combating blood-borne viruses’ to the ‘strategic recovery objective’, arguing that ‘It is self-evident that the best protection against blood borne viruses is full recovery’. For the UK Harm Reduction Alliance and co-signatories, including the UK Recovery Federation, this was not at all self-evident. Their response transformed the government’s *Putting full recovery first* title into *Putting public health first*, challenging what they characterised as an ‘ideologically-driven hierarchy’ which places ‘full recovery’ at the top, with ‘any other achievement marked as inferior’.

Attacking the roadmap, the Australian Injecting and Illicit Drug Users League insisted that ‘harm reduction is the goal – not a step along the “road to recovery”’, a formulation derived from their core belief that ‘all other approaches (eg demand reduction, supply reduction) can have validity only where there is strong evidence that they are appropriate, practical and equitable means of reducing drug-related harm.’

These polarities are endemic in debates about methadone maintenance, seen both as a treatment for dependence and a harm-reducing way to maintain dependence. In 2012 an expert group drawn largely from the UK drugs field attempted to reconcile these objectives. Complaining that ‘the protective benefits [ie harm reduction] have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery,’ they were prepared to see recovery pursued even if this ‘potentially more hazardous path’ risked relapse. At the same time, ‘preservation of benefit’ was seen as a reason for continuing treatment. Again the attempt was made to mount horses galloping in different directions – possible at a clinical level, but at a policy level, choices have to be made.

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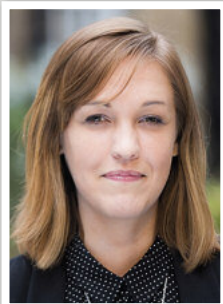
For some, the harm reduction benefits of remaining on methadone are a clinching argument in its favour, and a warning that an evangelistic recovery agenda will cost lives. Others think the risks worth it, arguing that ‘Leaving the protection of methadone maintenance treatment may increase the risk of death. But it might also be the way to a brand new life beyond your wildest dreams, where you find jobs, homes and friends.’ Leaving methadone is a dangerous business, but a proportion of former patients will swim rather than sink, and for some on the banks, the sight of those ‘recovered’ swimmers leaving methadone and addiction behind seems worth the loss of others.

Peacemakers try to gloss over the divides with, ‘We are all in the same game in the end, aren’t we?’, posing harm reduction and abstinence-based recovery as ends of an unbroken continuum of helping the patient, to which all can sign up. But in reality these are different games, their rules and aims deriving from differences in what we value most and how we see drug use: as always bad, or only bad if it causes harm.

*This article is based on the Drug and Alcohol Findings Effectiveness Bank hot topic, Harm reduction: what’s it for? Full text with links to documentation at [http://findings.org.uk/PHP/dl.php?file=harm\\_reduct.hot&s=dd](http://findings.org.uk/PHP/dl.php?file=harm_reduct.hot&s=dd).*

*Mike Ashton is editor of Drug and Alcohol Findings, [findings.org.uk](http://findings.org.uk).*

## LEGAL EYE



**Nicole Ridgwell** of Ridouts answers your legal questions

### Can I challenge the results of our CQC inspection? And if so, how?

#### NICOLE ANSWERS:

As previously reported in *DDN*, the July 2015 implementation of new comprehensive CQC inspections has brought significant regulatory change to the substance misuse sector. Feedback from the frontline is that this first inspection cycle has been predictably challenging.

At Ridouts, we see inspection reports in which policies are strongly criticised in one location while passing without comment in a sister service. The fundamental problem appears to be the variation in training and knowledge of CQC inspectors. Clients have described inspectors demanding evidence of compliance with NHS standards to which services are not subject, and criticism of services choosing a detox route differentiating from NICE guidance, not listening to the provider's cogent explanation of why they use a different but equally recognised tool for their client group.

Unfortunately this was foreseeable and, by choosing not to publish ratings at this stage, CQC tacitly acknowledged that this set of inspections was a trial run. That however is cold comfort to the providers faced with critical reports, enforcement action and damaging media headlines.

Providers need to feel confident in their right to challenge. Without challenge, CQC and the public will presume the provider accepts the content.

Preparing for the possibility of challenge is important. In theory, there should be no surprises when a provider receives a draft report. There should be sufficient feedback during the course of the inspection to headline areas of strength, as well as areas for improvement.

While feedback sessions are not an opportunity to debate findings, they should enable staff to begin gathering evidence to challenge and identify areas for improvement, with a view to responding to the draft report. Where feedback is insubstantial, providers must request further detail.

On receipt of the draft report, providers must scrutinise it line by line, identifying not simply factual inaccuracies but negative or imprecise wording and vague criticisms. Although this may seem laborious, it is important to lodge all valid objections. Should matters progress to enforcement action, it will be much more difficult to retrospectively challenge something about which providers were initially silent.

CQC guidance implies that providers can only challenge facts. That is wrong as a matter of law. CQC must take into account all written representations about the inspection process and the content of the report.

Providers in all sectors are intimidated by CQC and often feel powerless to exercise their rights. Successful challenges however not only correct falsehoods for individual services but also feed into CQC's reflections on their inspection process. This contributes to improvements in inspection training, to the benefit of your next inspection and CQC's understanding of the sector as a whole.

**Nicole Ridgwell is solicitor at Ridouts LLP, a practice of health and social care lawyers, [www.ridout-law.com](http://www.ridout-law.com).**

Send your legal queries to [legal@drinkanddrugsnews.com](mailto:legal@drinkanddrugsnews.com)

## FROM OUR FOREIGN CORRESPONDENT

### A chance to breathe

E-cigarettes could be the biggest public health intervention of our lifetime, says **Dr Chris Ford**



#### SLIGHTLY AMBIVALENT ABOUT THE CONFERENCE

**THEME**, I went to speak at the *Global Forum on Nicotine* in Warsaw in June – and had my eyes firmly opened. I got chatting to two people, both of whom were vaping. Eric, now in his late 60s, explained that he was a retired teacher and had smoked since he was 16 years old.

He had tried everything to stop smoking but nothing had succeeded. He had had chronic obstructive pulmonary disease (COPD) for the last few years and one bad night he googled 'how to stop smoking' and came across e-cigarettes, known technically as electronic nicotine delivery systems (ENDS). In all his years of trying to stop smoking, nobody had mentioned them to him.

Thinking 'What have I got to lose?' he ordered a basic e-cigarette kit and e-liquid and hasn't smoked a cigarette since. He needed to experiment with different nicotine strengths, temperature control and a variety of flavours before arriving at the right combination – but he hasn't looked back.

I knew after seeing a film by Aaron Biebert, *A Billion Lives*, ([www.abillionlives.com](http://www.abillionlives.com)) that I was on an amazing journey of learning. What struck me was the passion of these consumers and the struggle ahead. I was shown evidence of politicians, doctors and other health professionals speaking falsehoods, not looking at the evidence and taking a dogmatic stance.

The selling of tobacco for smoking is probably the most immoral and insidious form of drug dealing in the world – more than 6m people die every year from it. The companies producing this deadly product are largely based in countries where strict regulation of advertising, selling, and use, is in

place – however, about 80 per cent of the world's smokers live in poorer countries where almost none of these regulations apply. The top three global health problems – ischaemic heart disease, cerebrovascular disease and chronic obstructive airways disease – are directly related to smoking.

E-cigarettes are a highly effective intervention for those who can't or don't want to stop using nicotine. The Royal College of Physicians reports that risks using a vaporiser are unlikely to exceed five per cent of those associated with smoked tobacco products (<http://bit.ly/244lizv>). Yet even in the face of such obvious benefits, we are seeing bans in an increasing number of countries.

There seems to be a 'war on e-cigarettes', with vendors being prosecuted and even jailed in countries as diverse as India and Australia. 'Big pharma', who have put millions into nicotine replacement therapy, and tobacco companies, who have been left behind in the development, are both supporting the anti-e-cigarette propaganda.

E-cigarettes could possibly be the greatest public health intervention of our lifetime, and everything possible must be done to make them accessible to all. We must ensure that this new, much safer, way of consuming nicotine isn't just available in the richer countries, leaving the lethal hot smoke mechanisms to be sold in their billions to the poorest in the world.

*Chris Ford is clinical director of [www.idhdp.com](http://www.idhdp.com) Presentation at <http://bit.ly/2c40t0L>*

**'The top three global health problems – ischaemic heart disease, cerebrovascular disease and chronic obstructive airways disease – are directly related to smoking.'**



Bringing together social work students and people in recovery gave an opportunity to share skills and knowledge, as **Marelize Joubert** reports

#### ATTENDING A SUBSTANCE MISUSE CONFERENCE

with the theme of recovery gave social work students at Sheffield Hallam University the chance to find out more about drug and alcohol services, listen first hand to peer mentors' stories about recovery, and hear about what works in services. The conference, hosted by the university's social work department, also allowed the students to learn about career opportunities.

The rationale for the conference came from research by Professor Sarah Galvani and Debra Allnock that highlighted the gaps in knowledge and skills around substance use education that newly qualified social workers need before qualifying. This is brought sharply into focus by the increasing prevalence of substance use as a significant factor in child protection and safeguarding for both vulnerable children and adults, highlighted by the Social Care Institute for Excellence (SCIE).

A key feature of the day was collaboration with a wide range of social care and health practitioners, peer mentors and volunteers from Aspire, the commissioned drug and alcohol service in Doncaster. Aspire delivered a range of workshops that covered everything from parental substance misuse to the role of medication in assisting recovery. Volunteers and peer mentors were fully involved in the day, with one workshop focusing on the role of 'champions' in recovery.

'We were delighted to be involved in the conference being delivered to student social workers,' said Stuart Green, Aspire services manager. 'Aspire delegates were able to offer insight into treatment services and theoretical models of addiction from a hands on approach.'

Research also underpinned the day, with Prof David Best sharing his recent research around recovery, including the importance of relationships and connections. Research has shown that those who experience recovery can become 'better than well', he told students.



Best explained how change becomes more possible when research is backed up by the cost savings that could be made in economic and social terms by delivering recovery-based services. He gave an example of the importance of identity and visible recovery by sharing his research around the work in Blackpool by Jobs, Friends and Houses – a service that has the simple and effective idea of providing opportunities for jobs, housing and supportive networks to those leaving prison (*DDN*, June, page 8).

Michaela Jones added a political and personal context to the concept of recovery, talking about how services and recovery fitted within the current climate of austerity. A further session led by Dr Jamie Irving from the university's department of criminology and law, introduced the Sheffield Addiction Recovery Research Group (SARRG), which aims to establish Sheffield as a beacon of excellence around recovery in the UK.

Delegates heard how SARRG is peer-led and aims to support recovery-focused groups, and promote recovery-oriented activities and research. Through forging key alliances with local services such as Sheffield Alcohol Support Service, the Amy Winehouse Foundation and the local DACT, the group undertakes research and action to better understand the pathways out of addiction and into recovery.

One of SAARG's key aims is to help reduce stigma, by supporting partner organisations and helping to provide an evidence base that will inform best recovery practices such as the recovery capital measurement tool but one of its distinct characteristics is the very real partnership between those in recovery, researchers and services. By giving practical examples of some of the recovery-focused events that have been taking place in Sheffield – bike rides, conferences, workshops – he showed how they linked to research around the importance of feeling 'connected'.

The presence of peer mentors and volunteers as delegates and participants gave meaning to the term 'visible recovery', for as well as participating in the day's programme, they talked to students about their own experiences and felt empowered as 'community connectors'.

'The day was a great help in getting the perspective

**'Addiction is like a seeping wound and the impacts are significantly detrimental and corroding to the emotional, physical, financial and social wellbeing of the user and their families.'**

of potential social workers and an insight into what kind of concerns or questions they may have in their future roles, and having the opportunity to dispel certain views or misconceptions about addiction and recovery,' said one peer mentor.

Student feedback certainly seemed to confirm that they had also gained a lot from the day.

'Working with people hard to engage made me more aware of the issues of stigma, especially around how government policy drives this, to how a person may hide information due to shame,' said one, while another commented:

'Substance misuse can affect anyone for many reasons. Addiction is like a seeping wound and the impacts are significantly detrimental and corroding to the emotional, physical, financial and social wellbeing of the user and their families. I have learned that recovery can be successful with the invaluable support of expert, compassionate, non-judgemental workers dedicated to providing practical and emotional support to individuals in crisis because of addiction.'

*Marelize Joubert is lecturer in social work at Sheffield Hallam University*

PROMOTIONAL FEATURE

# RESONATING ISSUES



The Resonance Factor is a new model that puts accountability – and empowerment – centre stage, says *Kenneth Robinson*

There is nothing special about substance use, and this article deliberately refrains from terminology like ‘addiction, dependence and misuse’. Of course the individual requires support – and at times considerable support – however that is common to all relationship issues. For the drugs professional to make a monster out of it is one of the gravest mistakes in the field of substance use.

There is no simple intervention that has been devised to date to stop an individual from using substances, because substance use is ultimately based on the choice of the individual. There is a limited chance of an individual making changes to his or her life if they are unable learn and understand the very personal and intimate relationship they have formed with substance use – the same as for any individual looking to address any issue. Hence, is it surprising that some clients return over and over again to services if they believe themselves to be a slave and powerless to addiction?

The Resonance Factor model was created with this in mind. The central focus is the exploration of the user’s relationship with their drug of choice, which includes revisiting the *discovery* of that drug and the experience of the *high* – a pharmacological fact that tells us that drugs and alcohol affect each individual differently. This enables the service

The singular pursuit of the ‘high’, often maintained for many years, becomes the most important relationship for the drug or alcohol user.

user to consider how they use drugs and alcohol to change the way they think, feel and behave, and who they become when they have used. Let us not believe the ‘defensive’ nonsense of a client who says ‘I enjoyed substances when I first used them but I haven’t enjoyed them for the last ten years!’ In all honesty, does that make sense? If you believe the client to be an addict, sick, ill and the like then it makes perfect sense, but if you wish to understand substance use more deeply and understand the ‘wow’ factor of it all, then ‘I don’t like substances any more’ would not make sense.

The Resonance Factor does not avoid the issues that may have prompted the service user to access treatment – health problems, loss of relationships or children, housing, employment. These form the central platform of our therapeutic work with the client. It does, however, consider these issues to be pathways to and from the central issue that is the pursuit of the *high*. This singular pursuit, often maintained for many years, becomes the most important relationship for the drug or alcohol user, and is therefore the primary focus of the approach.

For the substance user to use at the expense of everything else, he or she has to create justifications, and maybe more thought and consideration should be given to that. The Resonance Factor is an approach that asks the service user to discover their accountability, while empowering them to make new choices.



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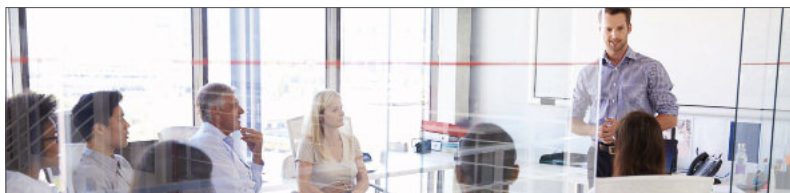
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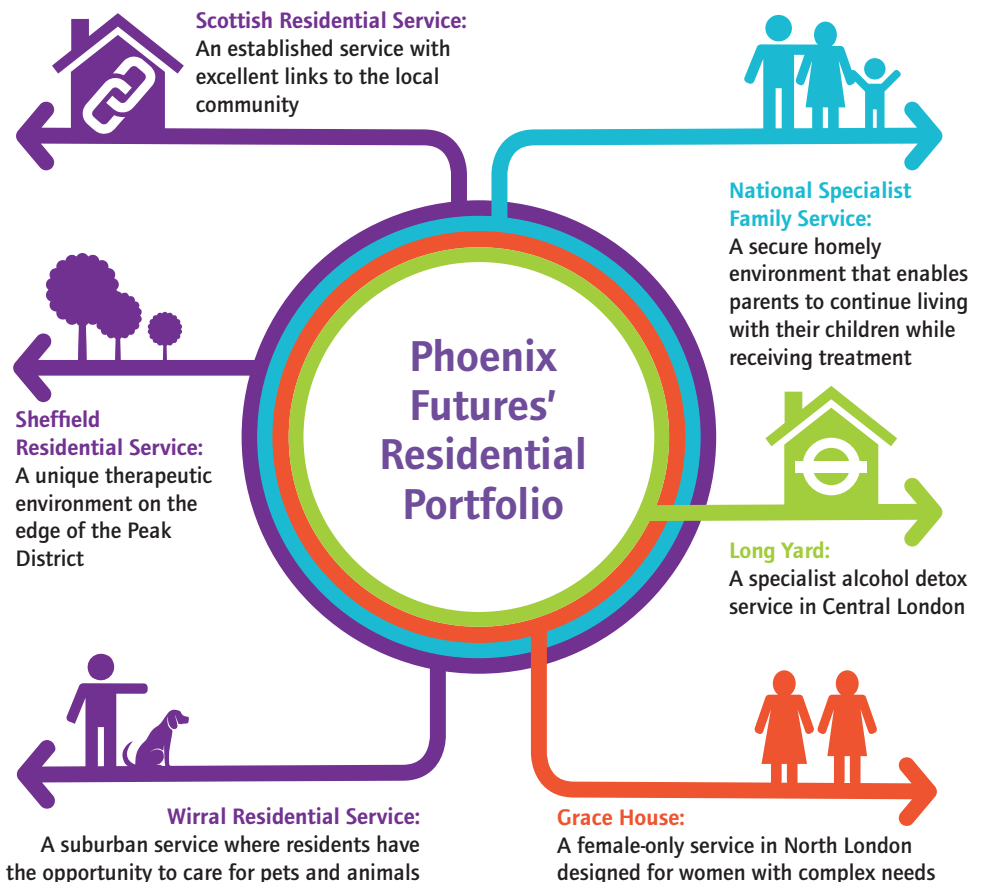
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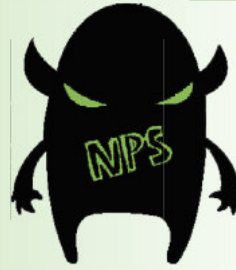
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## PROVIDER INFORMATION EVENT



# CONTRACT FOR AN INTEGRATED SUBSTANCE MISUSE TREATMENT SERVICE IN BUCKINGHAMSHIRE

Buckinghamshire County Council (BCC) is redesigning the adult substance misuse treatment system in Buckinghamshire. The system will move from the current two tier system to a single integrated service that will work across the whole of the county. The new integrated service will commence on the 1 October 2017 and will provide innovative harm reduction, comprehensive structured treatment, and robust recovery integration and support.

BCC will be running a tender process later this year and the resulting contract will be awarded for an initial period of five years with the option to extend it further by up to two years. This will be dependent on performance and subject to ongoing available funding. The value of the contract will be in the region of three million per annum.

The Council is of the opinion that Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) will apply to this contract.

The Council is holding a **Provider Information Event** in relation to this tender on:  
**Wednesday 5 October 2016 10am – 1pm**

We would like to invite interested parties to attend the event. This will provide the opportunity to:

- Gain information about Buckinghamshire and the needs of its residents
- Learn about the strategic direction for substance misuse prevention and treatment in Buckinghamshire
- Engage with Commissioners
- Gain information on the procurement process including key dates
- Visit the current treatment services in Buckinghamshire

To book a place at the Provider Event please email [rcarlile@buckscc.gov.uk](mailto:rcarlile@buckscc.gov.uk). For any general questions regarding the event contact **Becky Carlile** on **01296 387061**.

Attendance at the Provider Event will not give any advantage to potential bidders nor will your organisation be disadvantaged by not attending the event. All information provided at the Provider Event will be published on the Buckinghamshire Business Portal (the Portal) at [www.supplybucksbusiness.org.uk](http://www.supplybucksbusiness.org.uk)

The Council uses the Portal to advertise tender opportunities and run its tender processes.

To access the tender documents you will need to register on the Portal at [www.supplybucksbusiness.org.uk](http://www.supplybucksbusiness.org.uk). The documents will be published on the Buckinghamshire Business Portal in **November 2016**.



## TENDER OF DRUG AND ALCOHOL SERVICES IN BOLTON, SALFORD AND TRAFFORD AND FORTHCOMING PROVIDER BRIEFING EVENT

Bolton, Salford and Trafford Local Authorities are preparing to undertake a collaborative tender exercise for their drug and alcohol treatment and recovery services utilising a **Lead Provider Model**.

The Lead Provider will be responsible for delivery of the services which may include sub-contracting arrangements with other providers including third sector organisations. The Lead Provider will be responsible for coordinating service delivery between agencies as well as all financial, performance and governance functions. This will enable close cooperation between providers and ensure that clients can move between services and get the right help at the right time.

The successful Lead Provider will have a proven track record in delivering services that invest in recovery and social reintegration, recognise the importance of communities, families, and young people, and create a positive culture of partnership between service workers and users.

We will shortly be holding a Provider Briefing Event at which we will outline our vision of a treatment system that is both recovery focused and integrated across drugs and alcohol. This presents an opportunity to listen to our plans and network with potential partners.

The briefing event on the procurement of an Integrated Drug and Alcohol Recovery Treatment System will be held on 5th October 2016.

Further information can be obtained from the North West Business Portal 'The Chest', <https://www.the-chest.org.uk>

If you have not already done so, you can register "free of charge" on the portal and will receive notification of similar events and tender exercises that may be of interest to you.

# MORE

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