DRINK AND DRUGS NEWS

ISSN 1755-6236 **MAY 2017**

DDN

LIFE SUPPORT

IS THE SECTOR LIVING ON BORROWED TIME?

Latest news, views and jobs at www.drinkanddrugsnews.com

Trevi House

Where Life Begins

CQC on Trevi House:

Safe, effective, caring, responsive, well-led...

Read the full report at www.cqc.org.uk

MOTHER AND BABY RESIDENTIAL DRUG & ALCOHOL REHABILITATION CENTRE

Are you working with a mother or a pregnant woman who are motivated to change?

Trevi House offer the following support to facilitate change, whilst safeguarding the mother and child or unborn child:

An individual detoxification programme
Trevi House has a 100% success rate of women completing detox.

Varied accredited groups and individual interventions which cover three main areas of need

- Parenting – Incredible years groups, one-to-one play sessions
- Addiction – Recovery training and relapse prevention
- Healthy relationships – You and me, Mum group; Freedom programme and self-esteem work shops

24/7 support and supervision

Aftercare Support with our Sunflower Project

A nurturing and safe environment
Dedicated staff deliver high quality care to pregnant women and women with young children

Onsite Crèche
Our onsite Crèche is Ofsted inspected and we are a registered care home under CQC

Individual detox programmes

Treatment programme which provides varied interventions

Attachment focused parenting support and development

Growing and learning together

SAFER AND HEALTHIER FUTURES

For more information call Trevi House 01752 255758, e-mail office@trevihouse.org

DDN

Keep in touch with us via Facebook and Twitter!
/DDNMagazine @DDNMagazine

CONTENTS

EDITOR'S LETTER

'Who can offer the political leadership the sector needs?

Hogwash and purdah – it's election season again and where is the long-awaited drug strategy? The pages of this issue will tell you that we need change, but unlike many of the party political broadcasts they are specific about what's wrong and what must change.

From funding to commissioning to 'recovery outcomes' there is a sense that we are getting it wrong – and that politicians are refusing to listen. The evidence from within the sector comes down to one key question that is hard to ignore: why are politicians happy to condone a treatment system that costs so much but, despite the best efforts of those working in it, delivers so little? Whichever way you look at it, drug deaths are at their highest since records began and the toll of death and illness related to alcohol is just massive.

Our contributors are united in their condemnation of constant retendering, and the plea 'enough!' has been heard many times recently on these pages. The costly process has driven organisations out of business, treatment workers out of the sector, and cost how many lives? In the two years that it takes for a new provider to take over, clients are disconnected, lost – and possibly dead.

Over the past few years we have lost the post of 'drugs minister' – the named person who used to interact with the sector and shape policy from its expertise. A little bit of policy from this department and a little from that is doing nothing to bring the dynamism, accountability and results that this sector so desperately needs. Will this election offer a lifeline from any side?

Claire Brown, editor

Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

CJ Wellings

Published by CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT

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

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

Website:
www.drinkanddrugsnews.com
Website support by wiredupwales.com

Printed on environmentally friendly paper by the Manson Group Ltd

Cover by oceandigital/iStock

DDN is an independent publication, entirely funded by advertising.

Supporting organisations:

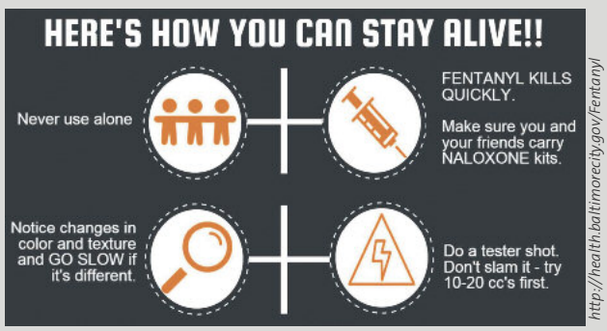
NATIONAL CRIME AGENCY ISSUES FENTANYL WARNING

THE NATIONAL CRIME AGENCY (NCA) has taken the 'unusual step' of warning drug users to be vigilant following the detection of powerful synthetic opioid fentanyl in heroin supplies in the north east of England. Fentanyl and its analogue carfentanyl are thought to have contributed to recent deaths among drug users in the Yorkshire, Cleveland and Humber areas.

Fentanyl is a licensed medicine used to treat severe and terminal pain, and is around 100 times more potent than morphine, while carfentanyl is more powerful still. Even in the 'unlikely event' that users know their drugs contain fentanyl, the risk of overdose is high, warns the NCA.

The NCA and West Yorkshire Police recently targeted a laboratory suspected of producing the drugs, and there are concerns that the substances could have been 'distributed to drug dealers across a much wider area', putting people in other regions at risk. While initial toxicology revealed fentanyl analogues in 'a small number' of the north east deaths, 'specific retesting has started to indicate that the influence of fentanyl is greater than first suspected', said the NCA's head of drugs threat and intelligence, Tony Saggers.

'We now believe UK customers beyond the north east region are likely to have received consignments of these drugs,' he continued. 'I am particularly concerned that drug dealers within established heroin markets may have purchased fentanyl, carfentanyl, or similar substances from this facility. They may not know how dangerous it is, both to them when they handle it, and to their customers.' The criminal justice implications of supplying fentanyl mixed into other drugs would 'inevitably' be deemed aggravating, he stated, and 'claiming ignorance of the consequences' would be no defence.



Public Health England has also issued a drugs alert to emergency services, treatment agencies and other bodies, urging them to advise heroin users to 'be extra cautious about the sources from which they get their drugs, and about the drugs they take, maybe starting with just a quarter hit of a new supply'. Drug services should also supply naloxone to 'all those at risk', it adds, while any areas seeing spikes in drug-related deaths should contact local coroners to establish if fentanyl is routinely screened for in toxicology results. 'If it is not, consideration should be given to resubmitting samples for retesting,' it states.

'We are urging heroin users to be extra careful about what they are taking,' said PHE's director of drugs, alcohol and tobacco, Rosanna O'Connor. 'They need to look out for each other and be alert to any signs of an overdose, such as lack of consciousness, shallow or no breathing, "snoring", and blueing of the lips and fingertips. If possible, they should use naloxone if someone overdoses, and immediately call for an ambulance. We strongly advise all dependent drug users to get support from local drug services.'

Drugs alert at https://www.cas.dh.gov.uk/Home.aspx

CRIMINAL CASH

TRANSNATIONAL CRIME is now valued at between $1.6tn and $2.2tn annually, with drug trafficking accounting for between $426bn and $652bn of that, says a report from Global Financial Integrity (GFI). Only counterfeiting is more profitable than drugs, says *Transnational crime and the developing world*. 'The fight against transnational crime needs to be redirected to combating the money the crimes generate,' said GFI president Raymond Baker. 'This means shutting down the global shadow financial system that facilitates the moving and secreting of illicitly generated funds. None of this is technically difficult. It is a matter of political will.'

Report at www.gfintegrity.org

HARM'S WAY

HARM REDUCTION RESPONSES in Europe are being limited by 'austerity, international donor retreat and poor political support' according to a report from Harm Reduction International (HRI). Some EU member states are experiencing funding crises that 'must be addressed if public health emergencies are to be avoided', warns HRI. *www.hri.global*

INCENDIARY ISSUES

SMOKING CAUSES ONE IN TEN DEATHS GLOBALLY, according to a study published in *The Lancet*. While the scale-up of tobacco control is a 'public health success story', smoking remains 'a major risk' for early death and disability worldwide and requires sustained political commitment, says *Smoking prevalence and attributable disease burden in 195 countries and territories, 1990-2015*. Meanwhile, the Royal Society for Public Health (RSPH) is calling on UK vape retailers to adhere to a code of conduct after an undercover investigation found that nearly 90 per cent of shops were 'either knowingly or unwittingly' prepared to sell e-cigarettes to people who had never smoked or vaped. 'High street vape stores are the visible face of vaping in the UK, and so it is crucial that they are seen as responsible retailers of evidence-based quitting aids, rather than lifestyle products,' said RSPH chief executive Shirley Cramer. *Report at thelancet.com*

It is crucial that vape products are seen as evidence-based quitting aids, rather than lifestyle products'.

SHIRLEY CRAMER

PHARMACY FIRST

PHARMACIES IN URUGUAY will be able to sell cannabis for recreational use from July onwards, the country's National Drug Board has announced. Uruguay legalised the cultivation, distribution and consumption of the drug in 2013 (*DDN*, January 2014, page 4), and so far 16 pharmacies have registered to sell five-gram containers of cannabis grown by state-licensed producers. Anyone wishing to buy the drug will need to sign up to a national registry, with maximum limits imposed on monthly purchases. Meanwhile, the Canadian government has introduced legislation to legalise and 'strictly regulate' cannabis, following its announcement at last year's UNGASS (*DDN*, May 2016, page 4). Subject to parliamentary approval, the proposed Cannabis Act would create a legal framework for controlling the production, distribution, sale and possession of the drug, with sales to anyone under 18 prohibited along with 'any products, promotion, packaging or labelling that could be appealing to young people', according to health minster Jane Philpott.

GLOBAL BURDEN

AROUND 1.75M PEOPLE WORLDWIDE were newly infected with HCV in 2015, says the World Health Organization's *Global hepatitis report 2017*, bringing the total number of people living with hepatitis C to 71m. Injecting drug use and unsafe injections in healthcare settings remain the most common transmission routes, states the document, which calls for a 'scaling up of harm reduction services – particularly access to sterile injecting equipment and OST. 'Viral hepatitis is now recognized as a major public health challenge that requires an urgent response,' said WHO director general Dr Margaret Chan. *Document at www.who.int/en*

TRUMP ADMINISTRATION TO STEP UP 'WAR ON DRUGS'

THE US ADMINISTRATION under President Donald Trump has signalled that it intends to intensify the 'war on drugs', with a return to 1980s-style prevention campaigns and the use of marijuana possession as a means to deport immigrants who don't have proper documentation.

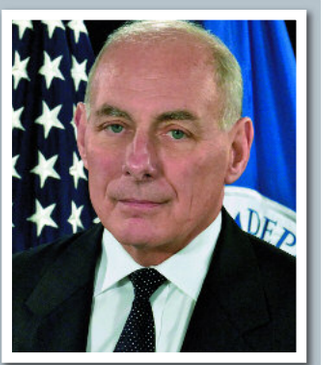
The direction is in contrast to that of the Obama administration, which steered prosecutors away from pursuing low-level drugs offenders, while one of President Obama's final acts in office was to commute the sentences of 330 prisoners. The 'vast majority' of these were serving 'unduly long sentences for drug crimes', the White House said (*DDN*, February, page 4).

'Let me be clear about marijuana,' said homeland security secretary, John Kelly. 'It is a potentially dangerous gateway drug that frequently leads to the use of harder drugs.' The US Immigration and Customs Enforcement department (ICE) would 'continue to use marijuana possession, distribution and convictions as essential elements as they build their deportation/removal apprehension packages for targeted operations against illegal aliens,' he stated.

While marijuana remains illegal under US federal law, eight states have now legalised the drug for adult use – including five which did so at the time of last year's presidential elections (*DDN*, December 2016, page 4) – and almost 30 states have medical marijuana laws. 'It's outrageous to think that anyone following medical advice under state law would be subject to deportation,' said policy manager at the Drug Policy Alliance's Washington-based office of national affairs, Jerónimo Saldaña.

The announcement follows a recent speech by US attorney general Jeff Sessions in which he praised the drug prevention campaigns of the 1980s and '90s and stressed the need to prevent 'people from ever taking drugs in the first place'. Treatment often came 'too late to save people from addiction or death', he said.

'Too many lives are at stake to worry about being fashionable,' he stated. 'I reject the idea that America will be a better place if marijuana is sold in every corner store. And I am astonished to hear people suggest that we can solve our heroin crisis by legalising marijuana – so people can trade one life-wrecking dependency for another that's only slightly less awful. Our nation needs to say clearly once again that using drugs will destroy your life.'



'Marijuana is a potentially dangerous gateway drug.' JOHN KELLY

President Trump is also expected to appoint a hardline drug war advocate, Tom Marino, as the next head of the Office of National Drug Control Policy – the country's 'drug czar'. Marino strongly supports a 'punitive, 1980s approach to drugs', says the Drug Policy Alliance, which called him a 'disastrous' choice. 'Our nation needs a drug czar that wants to treat drug use as a health issue, not someone who wants to double down on mass incarceration,' said its director of national affairs, Bill Piper. 'The American people are moving in one direction and the Trump administration is moving in another. There are few hardcore supporters of the failed war on drugs left, but those that are left seem to all be getting jobs in the administration.' *Jeff Sessions speech at www.justice.gov*

smoking as they are no longer seduced by glitzy, brightly coloured packs.'
Tobacco packaging design for reducing tobacco use at www.cochranelibrary.com

FOCUSED APPROACH

The Scottish Government should establish a target to reduce overall alcohol consumption by 10 per cent over the next decade, says a report from Alcohol Focus Scotland. The cut in drinking levels could potentially 'deliver a 20 per cent reduction in deaths and hospital admissions' after 20 years', states *Changing Scotland's relationship with alcohol: recommendations for further action*. 'Scotland is awash with alcohol,' said Alcohol Focus Scotland chief executive Alison Douglas. 'Widespread availability, low prices and heavy marketing are having a devastating effect, not only on drinkers but on their children and families too.' *Document at www.alcohol-focus-scotland.org.uk*

ADMISSIONS UP

There were an estimated 339,000 alcohol-related hospital admissions in England in 2015-16, a 3 per cent increase on the previous year but 22 per cent higher than a decade ago, according to the latest figures from ONS and NHS Digital. Using a 'broad measure' of admissions related to alcohol consumption, however, the number rises to 1.1m – up 4 per cent on the previous year. In both measures, Blackpool had the highest rate of admissions, says Statistics on alcohol England, 2017, which draws together new and previously released data from ONS, PHE, NHS Digital and other sources. Just over 25m adults reported drinking in the previous week, which equates to 57 per cent of the population – down from 64 per cent the previous year.
Report at www.content.digital.nhs.uk

PLAIN SPEAKING

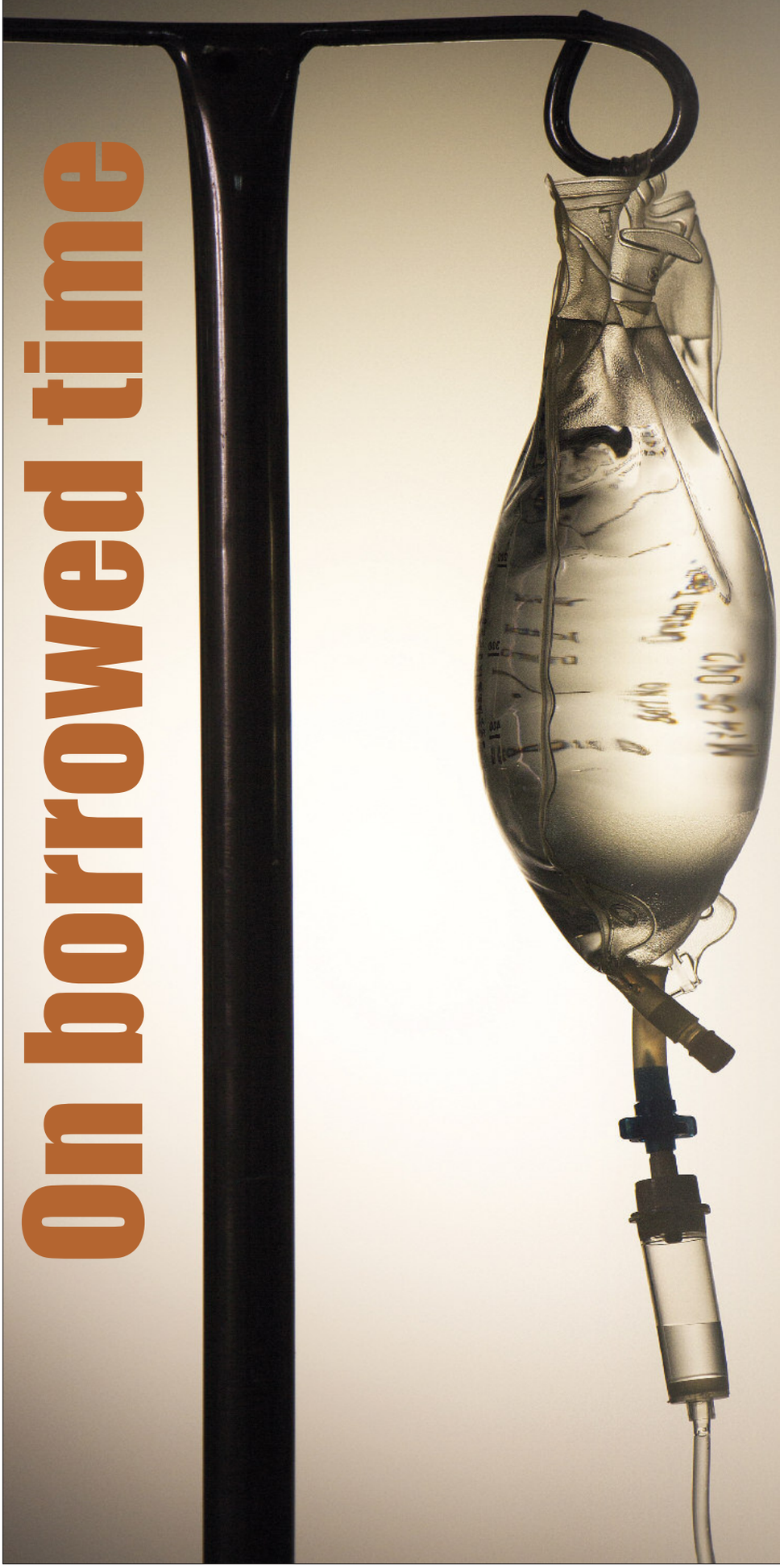
IT IS 'LIKELY' that plain tobacco packaging reduces smoking rates 'despite limited available research and only one country with the policy fully in place', according to a Cochrane review of international evidence. Full UK implementation of standardised packaging legislation will be complete later this month, following a 12-month period that allowed retailers to sell their existing stock. 'Standard packs are a landmark public health policy the tobacco industry fought tooth and nail to prevent,' said ASH chief executive Deborah Arnott. 'As evidence grows it is easy to see why. Smokers are already saying they feel differently about their pack of cigarettes and in years to come we expect to see fewer young people

SOCIAL CALL

THE ALL PARTY PARLIAMENTARY GROUP (APPG) for Dual Diagnosis and Complex Needs has launched a call for evidence around how social action can 'drive better services', for example by reducing stigma and improving joint working. The evidence will be presented at a roundtable event for health and social care leaders, followed by a report at the end of the summer. 'As the APPG has continually found, people with complex needs can remain at the sharp end of the inverse care law – requiring the most support, but receiving the least,' said APPG co-chair Lord Victor Adebowale. 'We hope this call for evidence will bring to light ways in which social action – whether that be formal volunteering, peer support, mutual aid or cooperatively managed services – can break down those barriers.' *Anyone with experience of the issues can contact sarah.cameron2@turning-point.co.uk until 20 May.*

'People with complex needs can remain at the sharp end of the inverse care law – requiring the most support, but receiving the least.' LORD VICTOR ADEBOWALE

On borrowed time



The delayed drug strategy – and lack of plan for an alcohol strategy – is pulling the lifeline from a sector in crisis, hears DDN

The new drug strategy is in limbo. Delayed for months without explanation, the questions are mounting against a backdrop of the highest number of drug-related deaths ever recorded. In the new year, the government said 'soon'. In February they confirmed 'shortly'.

On 30 March, Liz McInnes MP asked for a date for the strategy, telling the house: 'Local authorities have seen their funding for drug and alcohol treatment slashed by 42 per cent since 2010... there are more than 1m alcohol-related hospital admissions each year, and alcohol is a contributory factor in more than 200 different health conditions. Let us hope that both a drugs strategy and an alcohol strategy will be forthcoming as a matter of urgency.'

At the end of April, Sarah Wollaston MP asked the parliamentary under-secretary of state at the Home Office, Sarah Newton, when it would be published. She answered: 'We are currently developing the new drug strategy, working across government and with key partners. The new strategy will be published in due course.' With the general election taking place on 8 June, no one is expecting progress anytime soon.

Furthermore, there is no hint of an alcohol strategy, apart from in Scotland, despite problematic alcohol use affecting many more people than drugs.

At the latest cross-party parliamentary group on drugs, alcohol and justice, Colin Drummond, professor of addiction psychiatry at King's College London, was invited to speak about alcohol misuse and treatment.

He began by outlining the worsening picture on alcohol, stating that 'alcohol-related health conditions, including liver disease, have increased and alcohol-related hospital admissions have doubled.' But his talk went on to explore the deepening crisis for the drug and alcohol sector.

'We've had a world-class addiction system in the UK, and we're in danger of losing it. We're in danger of it not existing in a few years' time,' he said. Looking at the recent rise in drug-related deaths (DRDs) he referred to the government's reaction to a previous epidemic around 2001: 'In the 2000s we had a huge investment in treatments, so drug deaths began falling. But they're now at their highest since records began.'

So what's going wrong? Why are we failing? 'Declining resources for this population' were an obvious factor, combined with the disastrous effect of constant

retendering. Prof Drummond stated that 'people with complex needs are not getting the same access to treatment as before' and went on to say that the 'biggest impact of constant retendering is going to be on people with the most complex needs. They're not attractive people to treat – they're costly, with poor outcomes.'

Furthermore, when contracts are tendered, the expectation is that the service will see 'twice the number of people with half the amount of money,' he said. 'So they strip staff costs and have fewer qualified staff and more volunteers.' It was also an extremely expensive process – 'money that could have been spent on treatment instead of lawyers drawing up contracts'.

With retendering taking place every three years in local authorities, clients were constantly affected by the changeover process.

Add to this the loss of specialists to the field – 'in addiction psychiatry we've lost 60 per cent of training places in England' – and you have the perfect storm, he said. 'It looks like there are plenty of people in treatment, but the people in most need are being denied care. If they're not being taken care of here, they will pop up elsewhere – in A&E, GPs' surgeries and in prison... there is an artificial separation between health and social care.'

So what needs to change? Prof Drummond suggested immediate recommendations for the incoming government:

- **Ring-fence funding** that's going into addiction treatment. 'Ring-fencing needs to be safeguarded not further depleted,' said Prof Drummond. 'Cutting these services is a false economy. Local authorities will only see it from their perspective, but it will cost them more money in the long term.'
- **Bring the NHS back** into the fold: 'We felt it was wrong to put everything in the control of local authorities.'
- **Put a moratorium on retendering**. 'We see no evidence that it improves services.'
- **Protect specialism and experience**, eg addiction psychiatry. 'No area should fall over for lack of experience.'
- **Deal with people with complex needs** properly. 'We need to rebalance the system to do this – and if we don't treat them, they cost a lot to the economy.'
- **Back minimum unit pricing** (MUP). 'It would have huge benefits – to both moderate drinkers and to people at the severe end of the spectrum.'
- **Increase research capacity**. 'If we don't understand the impacts, we won't learn.'

Discussion between members of the APPG – which includes MPs, treatment providers, specialist and advisory groups and people representing service user and recovery communities – reinforced the need for action.

'We need a single government minister for drugs and alcohol'

The Drugs, Alcohol and Justice Cross-Party Parliamentary Group submitted a 'charter for change', calling upon the government to tackle drug and alcohol-related illness and deaths through investment, education, and a commitment to evidence-based practice.

Top of the list was the call for a single government minister to be responsible for drug and alcohol policy, accountable to parliament.

The minister would be empowered to:

- ***Focus drug policy on health, mental health and social inclusion, looking particularly at people with multiple needs, such as mental health issues and homelessness.***
- ***Develop a harm reduction strategy to reduce drug and alcohol-related deaths and illness.***
- ***Create a national commissioning ombudsman to ensure transparency and accountability.***
- ***Widen the Care Quality Commission (CQC)'s remit to include all local authority-commissioned drug and alcohol services.***
- ***Ensure competence and accreditation of the workforce by investing in an independent association.***
- ***Commit to reviewing drug policy at national and global levels, building on progress at last year's United Nations General Assembly Special Session on drugs (UNGASS).***

The minister's priorities should include following guidance provided by the Advisory Council on the Misuse of Drugs (ACMD) – including ensuring comprehensive access to the life-saving drug naloxone across the whole of the UK, and making NICE-approved treatments available to all patients diagnosed with hepatitis C.

'We've had a world-class addiction system in the UK, and we're in danger of losing it. We're in danger of it not existing...'

'A lot of this isn't new but political will is lacking,' said Alex Boyt, who worked for years in service user involvement. 'It's a lose-lose conversation – people who are not cost-effective are not being treated.' The 'relentless commissioning' also exacerbated the situation: 'Each time clients are lost, old and new providers blame each other.'

Prof Drummond said that 'those most affected by cuts have been rehabs', to which Caroline Cole, interim chief executive at Broadway Lodge, added: 'We've had to pull back on the numbers of people with complex needs as the local authority can't pay us what it costs us to treat them.'

The prison population was also being failed. 'There's a massive spike in deaths on release,' said Prof Drummond. 'The window when they come out is vital – we used to be better at that. There was better throughcare, but the programmes have been dismantled.'

'Work happens inside, but the problem is when they come out,' said a volunteer at a prison recovery service. 'Places are limited – there's nowhere to go – so they go back to old stamping grounds, old habits and back inside. I sat on a drug strategy group at prison and they do their best, but they're stretched – and once people are back inside they're lost again.'

'We see people who are retoxed in prison, put back on methadone, with no link with community services,' added Sunny Dhadley from the Service User Involvement Team (SUIT) at Wolverhampton.

'There seems an inability to have that very basic conversation about economic commonsense,' said Boyt. 'With the election looming, even fewer people are listening than usual. Is there anything we can be doing practically – other than lamenting – to make the case?'

'Why doesn't the treasury see the madness of the way we're running things? Why aren't they looking for a rational approach?' asked one MP.

'What we've done as a group is to approach all the ministers responsible [see left] and given them the evidence,' said Lord Ramsbotham, the APPG's chair. 'They've patted us on the head but not reflected the evidence. The cost of not doing one thing in an area is going to be seen in another – all exemplified in the lack of a national drug strategy.' **DDN**

ON A MISSION

Curing hepatitis C has become a reality and makes sense for the public purse as well as public health. So let's get on with it, says **Dee Cunniffe**

More info about hep C at www.drinkanddrugsnews.com

If you heard there was a disease that affected an estimated 216,000 people in the UK, including 160,000 people in England, and was contributing to an increased mortality from liver disease – one of the five 'big killers' – and also posed a significant public health risk, you might say that something should be done about it. In the case of hepatitis C, the ball has started to roll, but those of us who work in this area know that so much more could, and should, be being done right now.

Hepatitis C – also known as hep C or HCV infection – is a virus that infects the liver. It is usually spread through blood-to-blood contact, and if left untreated, can cause serious and life-threatening damage. It's for this reason that it is sometimes known as the 'silent killer' as it can remain undetected for many years – currently an estimated 40 per cent of people don't even know they have the condition.

We know that hepatitis C is a condition of inequalities, disproportionately affecting marginalised groups. Injecting drug use remains the major risk factor for infection in England, 50 to 80 per cent of injecting drug users are infected with hepatitis C within five years of beginning to inject (*Hepatitis C in London*, PHE, 2015).

Formed in 2009, the London Joint Working Group on Substance Use and Hepatitis C (LJWG) is a group of expert clinicians and patient advocacy and voluntary sector leads, working in collaboration with a wide group of stakeholders. Our common goal is to implement an integrated plan to drive improvements in the prevention, diagnosis, treatment and outcomes of hepatitis C in people who use drugs, and reduce the spread of the virus. Our ultimate mission is to prevent new infection in people who do, or who have, injected drugs (PWIDs) in London and to help treat and eliminate HCV as a public health threat.

Why is this important? Well, we know from the PHE figures that the prevalence of hep C among people who inject is higher in London (55 per cent) than elsewhere in England (45 per cent) and that currently there are around 60,000 people in London who carry the virus.

But here's where the figures get worrying. LJWG's Public health report on commissioning of HCV services in London for people who inject drugs (2013) found that only three per cent of people diagnosed with hep C in London are being treated – an even smaller proportion than the 4.2 per cent in the rest of the country), and only one in three London boroughs has a hep C testing-to-treatment pathway.

In London's prisons the situation is similarly poor, says PHE, with only 6.4 per cent of new receptions reported as having been tested, compared with 7.8 per cent in the rest of England. When people with chronic HCV infection remain undiagnosed, they in turn fail to access treatment. Often they will then present late with complications of HCV-related end-stage liver disease (ESLD) and cancer, which we know have low survival rates.

However, there is plenty that can be done about the current rates of hepatitis C in London and elsewhere around the country. The main causes of liver disease are alcohol misuse, obesity and viral hepatitis and of these, hepatitis C is the one most amenable to intervention. When the new wave of direct acting antiviral (DAA) drugs came onto the scene a couple of years ago, the outlook became significantly brighter for hepatitis C patients: this disease is now curable in 90-95 per cent of cases. This means that our vision to help eliminate HCV as a public health threat now lies in the realms of the possible.

Our work with substance users in London shows how much of a difference these new medicines have made. Our LJWG hep C care booklets, produced in collaboration with Magdalena Harris from the London School of Hygiene and Tropical Medicine, include comments from clients like Brad, who said: 'I'm thinking about my future in a different way now. I've started to be a bit more positive and started thinking right, I could get rid of this. If I get rid of this within the year, that's it, I've got a new life.'

> 'We know that hepatitis C is a condition of inequalities, disproportionately affecting marginalised groups. Injecting drug use remains the major risk.'

Or Ivan, who said: 'Getting shot of hep C, it's making me more confident... free... I just feel so much more lifted. I really do, and if it didn't work at least I was given the option, at least people are trying for me, they've not given up on me, thinking "he's not worthless". They're thinking "he's worth it, let's give him a hand".'

The LJWG is a member of the Hepatitis C Coalition, a national group of clinicians, patient groups, charities and other groups who also want to see a more coordinated and effective approach to testing, treating and curing people with hepatitis C in the UK, and greater emphasis on the prevention of new infections. Finding patients through community outreach – through drug and alcohol services particularly – getting them tested and on to treatment in a timely manner is ultimately a win-win situation: people suffering from hep C can get the disease out of their system and get on with their lives, while the NHS saves itself cash from having to treat advanced liver disease for the same patient later on down the line.

Liver disease costs the NHS around £500m every year and the figure is rising annually, so testing and treating for hepatitis C – especially among the most at-risk groups of people – should be a national priority.

That's before the severity of the public health risk is put into the picture. The sooner people are cured, the sooner they no longer pose a risk to others of passing on the disease. Among people who inject drugs, that has to be a major concern. The mantra of 'test, treat, cure' covers all bases and solves the issue.

The call to action therefore needs to be three-fold: increase testing, increase diagnoses and maximise treatment for all those with hepatitis C, especially for people who inject drugs. The LJWG is committed to working towards this goal and invites all those who share our vision to get involved with us.

Dee Cunniffe is policy lead of the London Joint Working Group on Substance Use and Hepatitis C

The LJWG will be holding its annual conference at the Guildhall in London on Tuesday 26 September 2017. For more information and to get involved, visit http://ljwg.org.uk

DDN WELCOMES YOUR LETTERS

Please email the editor, claire@cjwellings.com, or post them to DDN at the address on page 3. Letters may be edited for space or clarity.

'Young people at my son's school know all about getting hold of this drug [Xanax] but the school has done nothing to help parents or pupils by acknowledging the drug, let alone what to do about it.'

SENSE ON XANAX

Thank you for your comprehensive look at the risks of Xanax (*DDN*, April, page 6). Young people at my son's school know all about getting hold of this drug but the school has done nothing to help parents or pupils by acknowledging the drug, let alone what to do about it. I am lucky that my sister gets *DDN* at work, as I have been able to show the school information that gives the facts without scaremongering. I hope that they will actually use the info to start discussion on prevention before it's too late.

S Riley, by email

TIME TO TRAIN

Clive Hallam makes some good points in his article on talking therapies (*DDN*, April, page 18) but, because of the quantity of misinformation in the rehab sector and the paucity of most of the so-called rehab systems on which his observations rely, he understandably misses the main requirements for recovering addicts from their habit. OST is not a recovery from addition programme – it is merely a change of supplier and as Clive has rightly pointed out, too many talking therapies rely on the practitioner rather than on the process they use.

Society cannot afford to provide a police or medical minder for anybody for life, so any viable solution must sufficiently empower the addict to enable him or her to take control of their own life, and again help themselves. This means using a non-drug withdrawal, plus training in two things: giving them the knowledge of how to reach and maintain abstinence; and at the same time resurrecting their responsibility level to the point where they can run their own lives.

Substituting one addictive substance for another does not cure. Talking about one's addiction seldom cures, nor does so-called 'treatment'. But drug-free withdrawal plus training does work in enough cases to make it thoroughly worthwhile.

E. Kenneth Eckersley, CEO, Addiction Recovery Training Services (ARTS)

CHOICE IS LIFELINE

Thanks for your article 'More Choice, More Options' (*DDN*, April, page 14). It is essential that the role OST can provide in an individual's recovery is acknowledged, and not ignored as part of a desire for a 'one size fits all' abstinence based model.

I am in long-term recovery and am now abstinent from all drugs, but without the pause from the madness of addiction and the period of stability that my prescription created, I do not think I would be where I am today. It is also interesting to hear of new innovations within this sector, which will hopefully help to reduce stigma towards people on scripts and provide more opportunities for more people to start their recovery journey.

Max, by email

BOLD MOVES

The UK's drug policy approach is no longer fit for purpose. It's time to try something new, says Norman Lamb

THE LIBERAL DEMOCRATS have long been calling for wholesale reform of our outdated and catastrophic drugs policies. There is no doubt that the War on Drugs has failed to tackle the harm caused by illegal drug use, or support problematic users into treatment and rehabilitation. Instead, we put huge sums of money into the pockets of criminals. It is a completely stupid approach.

'The Liberal Democrats are the only party with a progressive, liberal, and evidence-based policy on drugs.'

While Labour and the Conservatives want to persist with the War on Drugs, however disastrous the consequences, the Liberal Democrats have been prepared to stand up in Parliament and call for the bold changes that are clearly required. We have recently been pushing for a debate in the Commons to force the government's hand, and had been close to securing one before Theresa May announced a general election. Hopefully we will be in an even stronger position to make the case after 8 June.

The Liberal Democrats are the only party with a progressive, liberal, and evidence-based policy on drugs. We strongly believe that the possession of all drugs for personal use should be decriminalised on public health grounds, but have also gone one step further by calling for a legalised and regulated cannabis market in the UK. It would allow the sale of cannabis from specialist, licensed stores, overseen by a new regulator. The model was proposed by an independent expert panel, which I established, before being formally adopted as Lib Dem policy in March 2016.

We have to be pragmatic. We know that people will continue to purchase and use drugs, so ensuring their safety and wellbeing must be our absolute priority. It's disheartening to see other countries adopt more enlightened approaches while Britain is stuck in the dark ages.

Drug and alcohol addiction stands alongside obesity and smoking as one of the biggest public health disasters the country faces. There is a moral imperative to ensure that treatment services are properly funded, which unfortunately hasn't been the case in recent years, but we also need to end our hard-line approach to drug addiction where people are too often punished instead of being diverted to treatment and support. The Liberal Democrats have been clear that we would invest more resources in public health, ensuring that every local area is able to provide strong services including treatment for drug and alcohol misuse.

Our message of hope is this: There is a political party committed to fighting to reverse the cuts we have seen to substance misuse services, to reforming our damaging drugs laws so that drug use is treated as a health issue rather than a criminal offence, and to delivering a properly-funded, world-class health and care service where nobody goes without the right support. Only a vote for the Liberal Democrats on 8 June will guarantee a strong voice on these issues over the next five years.

IN SEARCH OF ALTRUISM

A year on from 'View From The Coalface' (DDN, April 2016, page 17), the Mulberry Community Project is still alive and well and has ambitions, says **Keith Stevenson**

When I started up the Mulberry Community Project six years ago, people told me it wouldn't work. I approached the powers that be and they told me that they had no money to help us and that they didn't understand the concept of recovery houses.

Mulberry started with £250 in the bank and a lot of faith. We had help from Green Pastures, our partners from Southport who could see the vision, and support from the church at All Hallows in Blackpool, which has been a lifeline for us. We have seen other organisations come and go and huge pots of money being used and abused by others trying to do what we have done – helping people finding their road to recovery and out of the chaos.

We've now had six years of building the programme and working with people – some who wanted recovery and some who just wanted a roof over their heads; six years of sending people back into society to work, lead a productive abstinence-based lifestyle and enjoy life. We still get phone calls and visits from our past residents, and we catch up on how well they are doing and what they are achieving.

However there is so much more we could do, by offering work experience along with qualifications – so that when people leave, their readiness for work is obvious. To achieve this we need help. I have just been to the opening of a fantastic project in Blackpool that helps young people with terminal illness have holidays, and the vision and the dream is breathtaking. It is easier to raise funds for a popular charity like this than for one that helps recovering addicts; we are not a 'pretty' charity, and I know we are not alone in this. However we receive no funding from commissioners and we have to rely on what we earn and what we raise.

> 'We are not a "pretty" charity, and I know we are not alone in this.'

This may sound silly, but I want people who could give without expecting any return – to perhaps loan without making a profit out of it. I want altruistic people who are willing to be involved with helping people get back into society. I want £50k so we can build a project that is going to have a massive impact on people's lives, and those around them. We are a very small charity and that amount would be massive to us.

I want to help those who may never have had work, people who need training to expand their skills and who are looking for independence from the state, and I know it can be done. If there is anyone out there who has caught the vision, please get in touch and let's build something together to enable people to live the dream.

Keith Stevenson is founder and CEO of the Mulberry Community Project, www.mulberrycompro.co.uk

MEDIA SAVVY

The news, and the skews, in the national media

FOOTAGE FILMED BY THE MANCHESTER EVENING NEWS (MEN), and released this weekend to social media, shows an unsettling vision of a city centre flooded by users of Spice. The effects of Spice are distressing, at least to the unaccustomed eyed – but the people of Manchester have grown all too accustomed of late. So while the MEN may find itself criticised over issues of consent for releasing video of users stumbling about like zombies or lying, roaring, in catatonic poses, this also feels very much like a city's cry for help.

Grace Dent, *Independent*, 10 April

IN LABELLING PEOPLE USING SPICE AS ZOMBIES, the media have allowed us to forget that these are vulnerable people, who are using a terrifyingly obliviating substance to escape an unbearably boring, painful or depressing reality. They are not extras from a horror movie, but people who need support.

Henry Fisher, *Guardian*, 20 April

ONE OF THE GENUINE PLEASURES of life in the UK today is the daily parade of photographs of zombified imbeciles out of their boxes on synthetic cannabinoids such as Spice. There was a chap on Friday bent over double and keening, in the manner of a lobotomised baboon. Other photos have shown users beating their heads against concrete and, presumably, incurring no mental damage whatsoever, or simply lying prostrate in the middle of the road. The suggestion is that we should be terribly worried about this and do something about it. I am not so sure. The photos are a source of amusement, for a start, in a world short of amusing things. And think of what these people might be doing if they weren't rendered insentient and thus harmless by these chemicals.

Rod Liddle, *Sunday Times*, 9 April

WE ARE SO AFRAID of the drugs people take for fun, to feel good, or at least to feel different for a few hours, that we ban them almost reflexively and punish those who use them. Why? What's so bad about adults taking a vacation from the imperious reality we call 'normal' – a reality that, sorry to say, isn't decreed by God or nature but by culture, by a semi-arbitrary history of conventions? We should divert some of our hyped-up fear of abuse potential into a societal experiment, a sandbox, so to speak, for exploring the benefits of various popular drugs – drugs (such as ketamine, marijuana, ecstasy and psilocybin) that are illegal because people sometimes want to take them. Surprise, surprise: these drugs might just help people feel better.

Marc Lewis, *Guardian*, 3 April

VOTE OF CONFIDENCE

Phoenix Futures launches its new strategy this week, with the strapline 'The charity that is confident about recovery'. DDN hears about the ideas behind it from chief executive Karen Biggs

One of the key tenets of Phoenix Futures' new strategy, which will define the organisation's direction from now until 2020, is that it's time for both the charity and the sector as a whole to have the confidence to speak up, especially when it comes to issues like stigma.

'We were coming to the end of our last strategy and about a year ago we started to have a conversation within the senior management team about things like identity,' says Karen Biggs, and particularly the perceived differences between 'charities' and 'providers'. 'We kept coming back to that.' In the year that followed she consulted with staff via a weekly email, and began exploring ideas. 'Last year was a mad year for the sector, and over the course of it the sense of people in Phoenix identifying us much more as a charity than as a provider of government contracts was very real,' she says.

This went hand in hand with a feeling that far from stigma becoming less of an issue, it was actually on the increase. 'We're not a lobbying or a campaigning organisation in the slightest, but what my staff were telling me was that stigma is now impacting people's ability to move through treatment and achieve the life they want,' she says. 'So while we're seeing a reduction in stigma in mental health, what we're seeing in addiction is almost a re-stigmatisation of our client group. It's hampering our ability to do our best for our service users.'

So why is this happening now? 'I think when local communities have difficult decisions to make about where they spend their money, it becomes easier to identify groups that might not necessarily be thought as deserving as others,' she says. 'That feels like an awful thing to say about our society, but people are facing really difficult decisions and I don't think localism has helped because we've introduced that element of local politics into the process.'

The fact that substance misuse is a relatively small sector compared to other areas of social care means it hasn't been able to 'carve out that space that some of our colleagues have', she states, while some of the mechanisms that were intended to address those 'deserving/undeserving' issues and make sure that the needs of all groups were looked after in local decision-making haven't necessarily worked out for the sector's client group. 'I don't really see that the health and wellbeing boards offer any protection for addiction services, for example.'

As a result, the new strategy will have a focus on talking about addiction and stigma in a much more public, high profile way. The field has sometimes been accused of insularity and having conversations with itself – does she feel this is something it's shied away from in the past? 'When you look at other social care sectors like mental health or housing, we're relatively small and still relatively new. I think that newness makes that sense of confidence a bit more difficult to achieve, but I definitely think there's more we can do. Maybe there wasn't a need to do it before, but the sector has grown and more money has come into it. But you really test your mettle when things start to become a bit more difficult and you have to fight and evidence the values that your services are bringing to the wider community, rather than a particular group.'

Given that Phoenix started out as a grassroots organisation, how important has that voluntary ethos been over the years? 'Phoenix has a really strong connection with its history, and that sense of where we came from is really important to us,' she says. 'It's recognised in the importance of peers supporting each other in their recovery, it's really important to me, and it resonates with the staff – it's a real motivator.'

The new strategy is also about maximising resources – whether statutory funding or voluntary support – to widen and improve the services on offer. 'The important things in that new strapline are the confidence bit and the charity bit,' she states. 'There's a palpable sense in this sector of decline and marginalisation, and when funding's being cut across all those health and social care sectors, identifying as a provider of government contracts can at times challenge your values. It can be hard to see how you can deliver your organisational purpose, but if you switch how you think about yourselves and reconnect with that charitable purpose, you can see how a charity that's dedicated to supporting people affected by substance misuse fits in the world. You see how you can deliver your purpose in a much more meaningful way, regardless of what's going on with contracts and funding.'

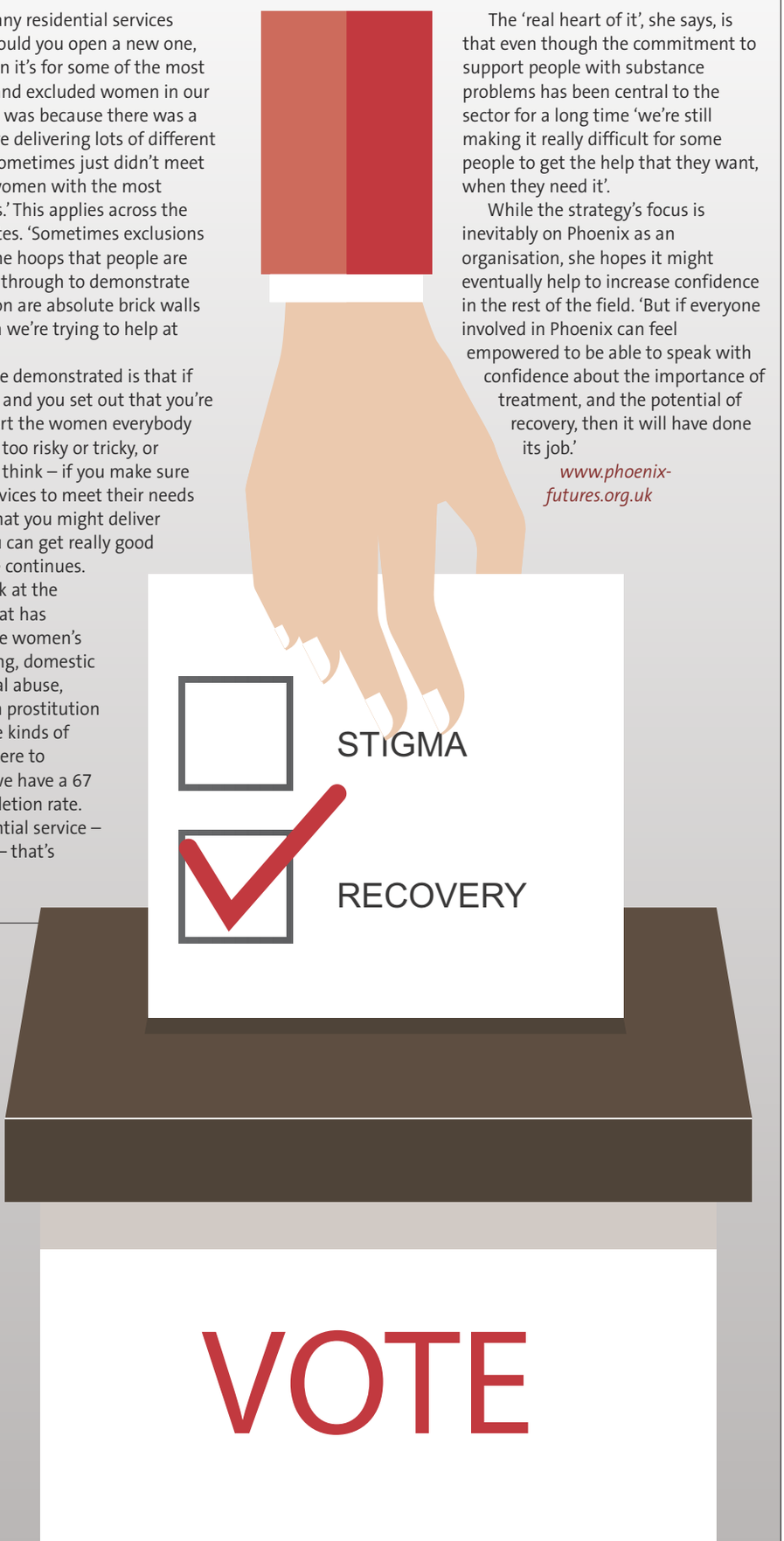
This then creates a 'much more credible fundraising offer', she stresses – 'targeted and

focused approaches to projects that complement the strategy', which means the organisation is now on the lookout for funders with similar values. 'It's the whole gamut – people can support us by working in partnership, there's different grants and trusts, there's business and private sector organisations looking to deliver their social purpose. There are people out there who are looking for good, credible charities who they can see operate with integrity, and they want to support them. It becomes a virtuous circle because it gives you much more confidence in yourself as a charity. Charities don't necessarily have the greatest PR, but that's what we are, and what motivates us to get out of bed in the morning is doing our very best for the people who need our services.'

There will also be an emphasis on making the whole idea of treatment less intimidating – being more open and helping to reduce the fear of the unknown. Does the field do enough to demystify treatment, or is this another area where it may have fallen down in the past? 'I think it's difficult with the level of stigma and this increasing sense of deserving and undeserving in our local communities,' she says. 'But different organisations and groups have come together over the last few years to see what we can do about stigma, and maybe now's the time when there's a sense of need and coming together. I do sense a real increase in goodwill in the sector amongst providers, and maybe that comes from difficult times.'

The strategy also addresses the thorny issue of well-meaning policies that can have unintended negative consequences, whether that's benefit or commissioning decisions, or even treatment criteria. She cites the example of Grace House, the London-based service for women with complex needs opened by Phoenix in 2015. 'Lots of people might have thought that was quite a strange thing to do – in the midst of so many residential services closing why would you open a new one, especially when it's for some of the most marginalised and excluded women in our community? It was because there was a need – we were delivering lots of different services that sometimes just didn't meet the needs of women with the most complex needs.' This applies across the sector, she states. 'Sometimes exclusions or criteria or the hoops that people are asked to jump through to demonstrate their motivation are absolute brick walls for the women we're trying to help at Grace House.

'What we've demonstrated is that if you open it up and you set out that you're there to support the women everybody else thinks are too risky or tricky, or whatever they think – if you make sure you deliver services to meet their needs rather than what you might deliver elsewhere, you can get really good outcomes,' she continues. 'When you look at the devastation that has impacted those women's lives – offending, domestic violence, sexual abuse, involvement in prostitution – those are the kinds of needs we're there to support, and we have a 67 per cent completion rate. For any residential service – or any service – that's really, really good.'



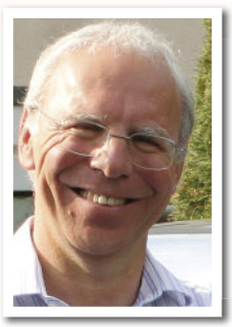
The 'real heart of it', she says, is that even though the commitment to support people with substance problems has been central to the sector for a long time 'we're still making it really difficult for some people to get the help that they want, when they need it'.

While the strategy's focus is inevitably on Phoenix as an organisation, she hopes it might eventually help to increase confidence in the rest of the field. 'But if everyone involved in Phoenix can feel empowered to be able to speak with confidence about the importance of treatment, and the potential of recovery, then it will have done its job.'

www.phoenix-futures.org.uk

'While we're seeing a reduction in stigma in mental health, what we're seeing in addiction is almost a re-stigmatisation of our client group.' KAREN BIGGS

STAY AHEAD OF CQC



Pleased with your CQC inspection or bruised by the experience? **David Finney** gives you the key issues

The first phase of inspections of substance misuse services by the CQC Hospital Directorate is now complete and all reports published. The experience of providers under this new regime has been varied: some received accolades, while others with previously excellent ratings have been severely criticised. Some services have even closed as a result of the new approach.

Sometimes CQC have 'requested' that providers temporarily suspend admissions while changes are made. This has been serious where there is a quick turnover of residents (in detox, for example) and numbers in treatment quickly reduce. Problems have also arisen when commissioners have been informed of negative comments in an inspection report, which has led to admissions being suspended or reduced.

CQC have already published the 'key lines of enquiry', used by inspectors, but many inspection judgements seem to be have been made according to additional criteria, such as NICE guidelines, extra guidance issued by CQC or simply the interpretation of regulations by the inspector.

Therefore, providers often ask me: are inspectors looking for services that replicate the NHS, or do they appreciate the distinctiveness of residential rehabilitation services, or the informality and reach of community-based services?

So, let us consider some of the issues attracting inspectors' attention:

1. **The Mental Capacity Act.** CQC expect that all staff have some awareness of what this act means for their service. Staff training is important, but staff also need to know what to do if someone lacks capacity while in the service, and how to assess for capacity in the first place.

2. **Governance.** CQC seem to increasingly expect an NHS-like system of accountability, where matters such as incident management, safeguarding, service user outcomes, key performance indicators etc are formally monitored; improvements made and risk registers produced. It is reasonable to expect corporate bodies to have such formal systems, but smaller services often have less formal ways of overseeing their work, which can be just as effective, but harder to evidence to the inspector.

3. **Ligature risks.** A focus on this topic springs from the mental health background of the CQC directorate inspecting substance misuse services. To my knowledge, there have been very few incidents of suicide risk in residential services, but now services are being expected to thoroughly examine their environment for ligature risks. CQC provide separate guidance about this issue on their website.

4. **Clinical issues.** These have been many and varied, but inspectors have often focused on assessment tools such as SADQ and CIWa for alcohol dependence and withdrawal, and other tests for drug dependence such as SDS. They often comment on the use of emergency medication such naloxone and rescue medication for seizures. NICE guidelines figure highly in CQC inspection reports, whereas they are only mentioned in passing in the 'key lines of enquiry'. There is also an expectation that providers have a multi-disciplinary team (MDT) in place; smaller services who are not equipped with an array of professionals on their staff team may have some difficulty explaining how they provide this.

5. **Care Issues.** These have included a wide range of subjects, from a lack of thoroughness in initial comprehensive assessments and seemingly low involvement of clients in their care planning, to the lack of privacy in shared rooms and the new topic of a requirement for same-sex accommodation (which seems to reflect concerns about mixed wards in the NHS).

6. **Statutory notifications.** There has been controversy over which deaths to report, especially in community services where service users may have infrequent contact with drug and alcohol workers. Exactly what qualifies as a death 'while receiving a service' is clearly up for debate with CQC. Other events, such as when police are involved or when a serious injury occurs, are also classed as 'notifiable incidents' by CQC, which providers can easily overlook. As it is a statutory requirement to make these notifications, CQC will deem any omission to do so as a 'breach of regulation', which has serious implications in terms of enforcement action.

These are just some of the issues causing concern and setbacks for substance misuse services – as if the funding crisis suffered by many services were not enough to dampen spirits. The CQC Hospital Directorate has certainly been making its presence felt during this round of inspections; so what of the future?

There is no public indication of when CQC will introduce ratings for the substance misuse sector, and the most recent consultation about CQC methodology amalgamated all the criteria into a generalised document that said very little about substance misuse services at all. Should providers just wait and hope for the best until we find out what CQC will do next – or is it better to actively prepare for the next round of inspections in the light of what we know already?

David Finney is an independent social care consultant who has been involved in the inspection of substance misuse services for 21 years, most of the time working for government inspection bodies. He is planning a training event to address these issues on 10 July.

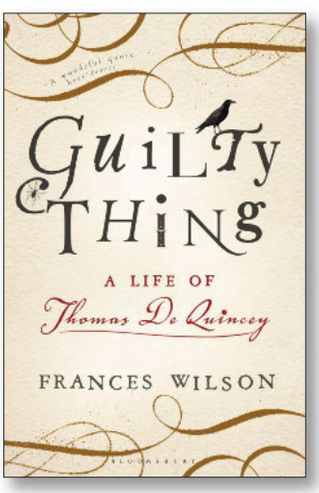
Lots more views and reviews at:
www.drinkanddrugsnews.com

BOOKSHELF

Recommended reading – from the drug and alcohol sector…

Guilty Thing – A Life of Thomas De Quincey

by Frances Wilson, published by Bloomsbury. ISBN: 9781782115489, £10.99
Review by Mark Reid.



Thomas De Quincey was the author of the renowned *Confessions of an English Opium-Eater*, first published in 1821. *Guilty Thing* covers De Quincey's many fixations, which also included poets and murderers.

At the time his drug of choice was very much the opium of the masses – used for almost every ache and pain. De Quincey appeared to champion its recreational use. When he first took opium in 1804 he hailed it as 'the secret of happiness, which philosophers had disputed, at once discovered'.

Were De Quincey to walk into a drug service today, there would not be that much a worker would not recognise in his underlying state of mind. What is striking is that he used opium to self-medicate his neuroses and ease his character defects in its dizzying dreams.

Frances Wilson asserts that 'addiction is now believed to be a shield against childhood trauma'. De Quincey exemplified this. His obsessive mindset was embedded by seeing the body of his nine-year-old sister Elizabeth who died when he was six. That sepulchral image prompted a lifelong search for the infinite and the sublime, which always had an element of terror at its heart. De Quincey later observed that 'an adult sympathises with himself as a child because he is the same and he is not the same'.

De Quincey the drug addict did his own cost-benefit analyses on his habit. He accepted opium was bad 'for health and vigour' and a 'personal appearance tolerably respectable'. But this change-talk was outweighed by opium's 'mastery over anger and fear, capacity for abstract thinking and emancipation from worldly cares'.

De Quincey did stop using opium sometimes: for 90 hours once. The result was 'unspeakable misery of the mind' in withdrawal with no substitute.

Another of his addictions was debt. Like opium this was born out of dread of ordinary life, allowing a second personality; apart and alone. Inevitably fear redoubled, as he was endlessly hunted by creditors.

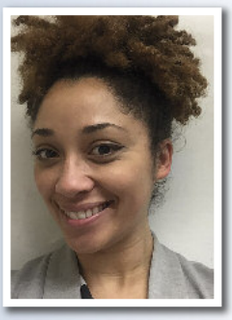
> When he first took opium in 1804 he hailed it as 'the secret of happiness which philosophers had disputed, at once discovered'.

Could modern-day counselling, medication and a programme of recovery have turned the opium-eater around? Can you imagine being Thomas De Quincey's keyworker? If so, this many-sided and accomplished biography is for you.

Mark Reid is participation and recovery worker at East London Federation Trust Addictions Services

CLINICAL EYE

A mutual respect



Ishbel Straker joins us as a regular columnist to give insights on nursing in addiction. This month she asks, why is there tension between doctors and nurses?

I WANT TO START BY SAYING I LIKE DOCTORS. I like what they do, what they stand for and their practice – in fact, some of my best friends are doctors! So why am I talking about the occasionally/more often than not strained relationship between a doctor and nurses?

When I trained a decade ago, I decided psychiatry was the place for me – not only because of the subject matter, but also the relationships between nurses and doctors. During placements on the general ward I would witness nurses who had 30 years experience behind them putting their knowledge to one side in favour of a third-year medical student.

Now, don't get me wrong, I absolutely value doctors – their skill is essential. However a mutual respect seemed to be lost in translation within the general and paediatric wards I was placed on. I was drawn to the relationship between the psychiatrist and the psychiatric nurse as it was one of mutual respect, with a clear understanding that both roles were equally important and neither could work as effectively for the patient without the other.

When I moved into addictions, this working relationship continued and progressed. Over the years I experienced some fantastic working relationships with doctors and watched the coordination of skills within the addictions services, which I feel has been the backbone of excellent care for substance misuse clients. However, I am sad to say, I have also witnessed the recent demise of this relationship and I question whether this is due to the rise of the non-medical prescriber (NMP).

The field of addiction has become the NMPs' stomping ground on which they have thrived. We now have clinical leads who are NMPs, when ten years ago this would have been unfathomable. Services are recruiting prescribers competitively and no longer differentiating between doctors and NMPs, but deciding who has the best skills at interview.

This is a fantastic step for nurses but one that has destabilised our medical colleagues – at times affecting our relationships. I hear of doctors terrifying NMPs with the dangers of what they are doing, highlighting the risks – and I wonder, is this down to a lack understanding of the jurisdiction of an NMP or is it a deeper issue?

One thing I can conclude is that if we are to provide the best treatment we can for our under-represented client population, then we must work together. We must keep the client at the forefront of our minds and not our own agenda. We must utilise one another's skills and not be fearful of what each other brings to the table.

Ishbel Straker is clinical director for a substance misuse organisation, a registered mental health nurse, independent nurse prescriber (INP), and a board member of IntANSA.

ACT Peer Recovery™ (ACT-PR) is a new form of mutual aid recognised by Public Health England.

GET IN ON THE ACT

WHAT IS IT?

ACT-PR is very simple. So simple it takes just 60 seconds to get started. Try it for yourself on the website – push the 'start learning' button. However, just because it's easy to learn doesn't mean it's lightweight or not backed up by research.

ACT-PR is based on Acceptance and Commitment Therapy (ACT), which has an evidence base on a par with CBT. The peer model is based on the ACT Matrix, which is a simpler training format.

It was developed in Portsmouth from 2008 and eventually grew to 20 groups per week across the whole community, from the general hospital to the library. In 2013 the peers wanted to make it available more widely, and a community interest company was established. Information days were held in Manchester with Emerging Futures and it also caught the attention of PHE in relation to FAMA (facilitated access to mutual aid). ACT-PR was approved for inclusion in the new policy guidelines in July 2015.

Since then ACT-PR has grown steadily, and there are over 40 meetings a week (excluding Portsmouth) across 12 local authority areas, with a further 15 areas developing. A new group opens on average every week, and that is accelerating.

SO HOW DOES IT WORK?

The unique feature of ACT-PR is its simplicity, achieved via focus on behaviour (see the short introductory videos). Behaviours are divided into two categories – those that take you towards recovery, and those that take you away. By learning to notice this difference, peers begin to reduce the 'away' behaviours and increase the 'towards' behaviours. In a nutshell, that's it.

Recovery is defined as building a life of meaning and purpose in the community. The backbone of the programme is the monthly challenge in which each peer chooses to make a significant behavioural change. Sometimes it's successful, sometimes it isn't. But what's important is to learn by a trial and error approach in which failure leads to success.

'ACT-PR is so simple it takes just 60 seconds to get started.'

The only requirement for attending an ACT-PR meeting is that you commit to a challenge. Of course there are obstacles – we call these 'lemons', summed up in the programme's key metaphor 'passengers on the bus':

'Building your life can be like driving a bus (behaviour) in a certain route (direction). However, when you start driving the passengers (lemons) get upset and bother the driver, who usually responds by trying to get them off the bus. Problem is, then the bus doesn't go anywhere, or even crashes.'

This is where acceptance comes in – some painful thoughts and feelings like anxiety, sadness or guilt are part of life. The commitment part is driving the bus with the passengers on board. So you learn to become 'comfortable with being uncomfortable' – the key to freedom and a better life.

STRUCTURE

Meetings are arranged at different levels, each divided into eight lessons delivered from a manual by the peer facilitator. The facilitators are trained, supported and licensed to ensure quality. The meetings are always open access, voluntary and independent.

FAMA

The new videos mean that anyone can be introduced to ACT-PR in 60 seconds, and connected to mutual aid. This can be built into the assessment process so that everyone has access to mutual aid right from the start.

Licensed peers also run basic level 'introduction to ACT-PR' meetings as part of their service roles, providing a joined-up pathway into mutual aid. ACT-PR fits very well with the 12 steps and SMART so it is another choice for people entering recovery.

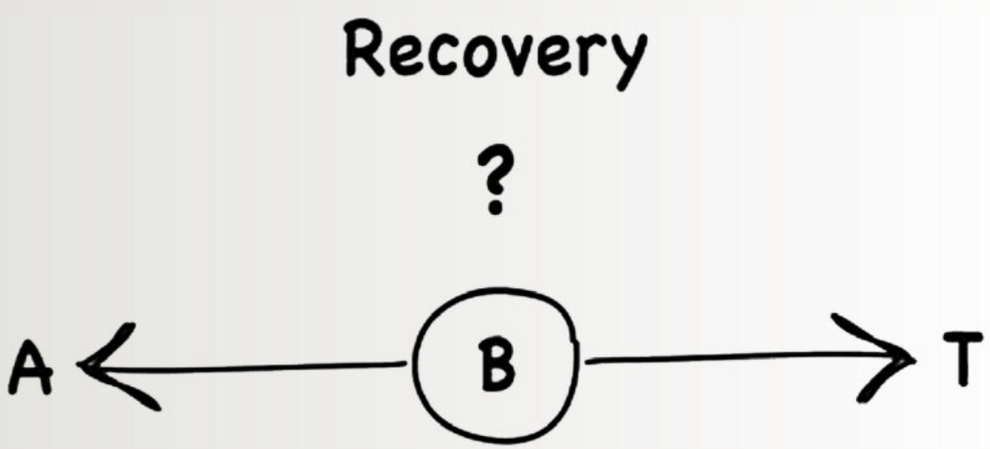
ONLINE

An online version of ACT-PR is being rolled out, with the first level a simple introduction, followed by an interactive version of the lessons. This makes ACT-PR available to anyone with internet access, and in time individual peer-to-peer support will also be available online.

BEHAVIOURAL HEALTH

As a behavioural approach, ACT-PR can be applied to many conditions that people face in recovery, from anxiety and depression to diabetes and pain. The peer approach can work with anything that is behavioural.

Mark Webster is CEO of ACT Peer Recovery. To find out more visit www.act-peer-recovery.com



‘Of course there are obstacles – we call these “lemons”.’

ACT-PR IN BRISTOL

I first came across ACT-PR at a FAMA training day in 2015. What appealed to me was the focus on behaviour and I also liked the fact that it wasn’t measured in terms of success/failure. I followed it up and if memory serves, the first conversation went like this:

Me: We don't have any peer organisations in Bristol.
Mark: Set one up.
Me: How do I do that for ACT Peer Recovery?
Mark: You’re doing it right now.

We agreed that an information day would be a good place to start, and in spring 2016 Bristol City Council gave us a small sum to host it. Mark came with four peers and they presented ACT-PR to us – everyone got it straight away and the first group was set up in October 2016. Twelve of us started in a space at Bristol Drugs Project, and it was amazing how things suddenly begun to click.

We’ve now finished the group leader training and have four new ACT meetings, including an LGBTQ+ meeting. We’ve formed a small charitable organisation and found office space. We have several people interested in doing the next round of group leader training in September.

With my peer colleagues we have worked hard to get ACT-PR off the ground because we have all benefitted from the model ourselves – developing our noticing muscles, loving our lemons and changing our lives. We really have ‘just done it’.

Jamie Freeman

THE PEER EXPERIENCE

‘Past/present/future’ is a format from the meetings:

Past: I used to react, get angry and be confrontational which caused arguments at home, filtered down to my children and rippled out to the rest of my life. It caused problems everywhere, including work.
Present: ACT-PR helped me get a pause button so I could notice my behaviours in advance and stop myself. Now I talk instead of shouting and choose my words carefully.
Future: Life has got a lot more peaceful and relationships have improved all round. I am no longer this ogre that people are frightened of. I have become more approachable, and get on so much better with everyone.

Female parent, 40

FAMA, WARRINGTON

After assessment we started to tell people about ACT-PR. They could attend a short introductory session that is held every week at the same time, so staff know when it is.

From the beginning it has been well attended and we have seven or eight people coming each week to learn the basic principles. In the year we have seen over 200 different people at these introductory sessions. Half go on to the full mutual aid meeting that we also run in the building. After that there are the community groups which attract a wide range of people.

We are now getting ready to use the video introductions at assessment time, and expect the numbers to grow even further. The results speak for themselves, and many people have stayed the course and developed recovery in the mutual aid groups.

BRIC worker

THE FACILITATOR EXPERIENCE

I attended a meeting and had a lot of ‘penny-drop’ moments – it really made sense to me, so I wanted to see if I could help out. I started by doing small parts of the meeting while the leader supported me, like a mentor, until my confidence improved. Once I was comfortable doing that I attended the six-week training course.

I enjoyed the course because it was very practical. We didn’t just sit there and listen – we had to have a go and get out of our comfort zone. As the weeks went by my confidence improved and by the end I was ready to start my own group, which you have to do to get a licence.

Now I run my own group and have watched the attendance slowly build. It makes me feel very proud to see people starting out on the process that I followed. One day I’ll hand it over to them and go on to the next level. And yes, it’s still scary – but it works.

Lancashire male, 36

‘Life has got a lot more peaceful and relationships have improved all round.’

Edward Dulac/Alamy

THE EMPEROR'S NEW CLOTHES

Pockets of good practice throughout the country should not mask the fact that the 'recovery agenda' is failing, says *Howard King*

Since the end of the last decade the substance misuse field has been increasingly focused on recovery. From the way we all talk about it you could be mistaken for thinking that there has been a substantial and consistent increase in the recovery rate nationally. Unfortunately that has not been the case, and indeed there is a marked absence in terms of any debate regarding how as a sector we are performing. So here are two figures that stand out.

1. *According to the NDTMS website the current recovery rate for opiate users is 6.6 per cent – a drop from 8.59 per cent in 2011-12. For all service users the rate is 38.24 per cent – a rise since 2011-12 of just 3.52 per cent.*
2. *During the same period, drug-related deaths have risen and continue to rise. They have risen higher than at any point since data was first collected in 1993.*

All major providers talk about their commitment to recovery, but what about outcomes? The evidence seems to indicate that as the recovery narrative has driven commissioning practice, the recovery rate has actually declined. We cannot ignore this clear disconnect between the narrative and the outcome.

If you were in central government and could see that all the investment into the field in recent years was achieving an annual recovery rate of only 6.63 per cent, and that this had consistently dropped year on year, then surely, in this time of evidence-based practice, you would want to review how you allocated resources?

Other areas of health and social care are expected to achieve so much more than the substance misuse field. IAPT (services for improving access to psychological therapies) for example, has a target of 50 per cent recovery. While it is important that we lobby for resources to be directed into people with substance misuse needs, perhaps we as a sector should also be doing more to actually deliver positive outcomes consistently across the country?

Of course it's not just providers who are responsible for this current situation. Commissioners have played a central role in this also. Service specifications proclaim the need for recovery-focused services, but in most cases when commissioners change service providers, the recovery rate in the first year drops and it takes 18 months to two years for the new provider to achieve what the old provider was doing – if indeed there is any improvement at all. This isn't good for service users and the view sometimes taken by commissioners that changing provider improves services is not generally supported by the evidence.

A recovery rate that has dropped to 6.63 per cent nationally proves that the current commissioning process is not generally achieving its goal. Changing providers on a regular basis does not seem to work and can negatively impact on patient care. Competition and best value is important but patient safety and consistency of provision should not play second best. Re-tendering is always an option, but one that should only be seen as a last resort when a service is failing and agreed remedial action plans have not led to the required change. It should not be the first response or an automatic reaction to contracts coming to an end, as evidence suggests this does not improve performance.

In addition to declining recovery rates, there is also the worrying trend of rising drug-related deaths. It is difficult to make a definite correlation between rising deaths, the emphasis on a recovery agenda which fails to deliver real recovery, and changing delivery models driven by increasing financial constraints. The emphasis placed upon an organisation's ability, resilience and expertise in providing services that are correctly governed is often undervalued in procurements. The duty of care to service users extends not only to providers but also to those who commission services, and we all need to be held responsible for services when the recovery rate drops, drug-related deaths rise, trained professionals are replaced by unqualified staff and prescribing practice deteriorates.

This is not to say that the recovery agenda has not driven improvements in our field. Seeing the amount of peer-led recovery events that are taking place, the more powerful user voice and the ideas that are discussed about what recovery can mean, is hugely encouraging. However overall this shows that there are pockets of good practice, but these are not embedded ways of working that are consistent across the country. We can't hide from the national figures or pretend to ourselves that it is everybody else or a handful of poor performing projects.

We do need to be careful about pushing a narrow concept of recovery onto those that aren't ready or aren't able. I am not suggesting that clients should be forced to reduce scripts or to detox against their wishes. The first aim of treatment should be to keep clients safe and harm reduction must be central to any treatment system, as should options for maintenance prescribing and long-term support. However, If we as a sector are saying that 6.63 per cent recovery is the best we can achieve without force, then we need to stop saying our services are recovery focused and look at other outcomes to prove what we are doing adds value to the communities we work in.

It's time that we started to have an open and honest conversation in the field about recovery. While it is important to highlight good practice, it doesn't change the fact that 6.63 per cent is a low recovery rate and the fact that more clients are dying is an uncomfortable truth. The reorientation of the drug treatment provider landscape may have reduced cost and increased competition, but it hasn't brought a forward a leap in terms of recovery, innovation or best practice. Ironically a by-product of this is the demise of many small and medium sized drug treatment providers, creating a less divergent market place and potentially losing the localism that these smaller agencies provided.

We, providers and commissioners, need to do things differently if we want things to improve for service users. What we have now isn't working, and funding will be lost if we don't improve or change the discussion on what recovery means. Fundamentally it's time that the sector actually offered meaningful, consistent, focused and evidence-based recovery-orientated services to our clients, based on an agreed range of outcomes.

Commissioners need to change their approach and not see re-tendering as the solution to their problems; if a service is working leave it alone and if it needs to improve, work with the provider to make it happen. Commissioners have tried financial penalties, retendering and changing providers, but in many cases the systems they oversee are producing worst results than they did five years ago. Isn't it time to listen to the evidence and try a different approach?

We shouldn't lose sight of the fact that many services provide a comprehensive range of effective interventions to service users, many of whom make significant lifestyle changes that improve their quality of life and also that of their family and wider community. We should celebrate these individuals and their success – but to say that as a sector we run recovery-focused services when so few of our clients achieve recovery is just not true.

Howard King is head of Inclusion

More about painkillers at:
www.drinkanddrugsnews.com

James Elander shares his new research on painkiller addiction and how to spot the warning signs

A DIFFERENT pain

Addiction to prescribed pain relief is a serious and growing problem. With 4.7m people in the US dependent on painkiller medication and numbers in the UK rising quickly, it is being described as a potential public health disaster.

Many people take painkillers to help them live with pain, with some becoming addicted to the medication – making their pain even harder to control. Other people are so afraid of addiction they don't take painkillers and suffer unnecessarily from pain.

It is hard to get the balance right between the benefits of painkillers and the risk of addiction, so a quick way to tell if you are at risk could help people manage their pain better, as well as help the health professionals who work with them.

With a team of researchers at the University of Derby, I have carried out some new research into painkiller addiction. Our study identified two key questions that people can ask themselves to find out whether they are at really at risk of addiction to painkillers, or if they are worrying unnecessarily.

They are:

- **Would you be unwilling to reduce your pain medication?**
- **Do you feel you depend on your pain medication?**

If your answer to both those questions is 'yes, definitely', you can take steps to reduce your risk of addiction to painkillers. On the other hand, if it is 'definitely not', then perhaps you are more concerned about addiction to painkillers than you need to be.

Our research used information from 683 people with different types of pain, the most common of which were headaches, back pain, joint pain, muscle pain and period pain.

The painkillers that were the most commonly used by people in the study were strong opiates such as morphine, fentanyl, and tramadol; weaker opiates such as dihydrocodeine and codeine-based compounds such as co-codamol; and non-opiates, mainly non-steroidal anti-inflammatory drugs such as naproxen, diclofenac, and ibuprofen.

One aim of the study was to find key signs of how likely a person is to get addicted to painkillers. We produced a short questionnaire to measure different aspects of people's concerns about painkillers, and their answers to those two key questions were the best predictors of how addicted or psychologically dependent they were on painkillers.

The research combined data from three studies by myself, Dr Frances Maratos, reader in emotion science, Derby PhD students Omimah Said and Malcolm Schofield, and undergraduate psychology students Ada Dys and Hannah Collins.

The studies were funded by a university research for learning and teaching fund grant, a British Psychological Society undergraduate research assistantship bursary and a university undergraduate research scholarship scheme bursary.

In the first study, people completed a pain medication attitudes questionnaire with 47 questions and had their painkiller dependence measured. The links between their answers to each of the 47 questions and their dependence score were then examined to produce a version with just 14 carefully selected questions.

In the other two studies, different groups of people with pain completed the version with just 14 questions. This short version worked as well as the one with 47 questions, and in all three studies those two key questions consistently predicted how dependent on painkillers people were.

These findings build on previous University of Derby research, published in 2014 in the journal *Pain Medicine*, which showed people were more likely to become dependent on painkillers if they took more prescription painkillers more often, had a prior history of substance-related problems, or were less accepting of pain.

This showed that there was more than one way to become dependent on painkillers, so people who answer 'yes' to the two questions identified in the most recent study might then use these questions to reflect on how the way they use painkillers may be developing into an addiction:

- **Am I using strong painkillers more often than I used to?**
- **Am I using painkillers a bit like I used to use drugs or alcohol?**
- **Am I getting more sensitive to pain, or having more trouble living with it, than I used to?**

We hope to use the findings to develop better information and education for people about painkiller addiction.

For the moment, anyone who is worried about how they use painkillers should talk to their doctor, or pharmacist, or even a friend or family member about how their relationship with painkillers may be changing.

They could also use the information that is already available, including the website of Cathryn Kemp, author of *Painkiller Addict – From Wreckage to Redemption* at www.painkiller-addict.com.

James Elander is head of psychological research at the University of Derby

Why are smokers reluctant to exchange the risks of cigarettes for the health benefits of e-cigs, asks **Neil McKeganey**

SLOW ON THE DRAW

E-cigarettes have been characterised by Public Health England as being as up to 95 per cent less harmful than combustible cigarettes. On the basis of that figure, and the fact that smoking kills around one in two of all smokers, you would have thought that smokers would be heading towards e-cigarettes in their droves – but that does not seem to be what is happening.

According to the UK charity Action on Smoking and Health (ASH), there are approximately 2.8m people in the UK who are using e-cigarettes, 51 per cent of whom are current smokers. ASH has also estimated that there are approximately 9.1m adult smokers in the UK. On the basis of those figures, only around 15.6 per cent of adult smokers in the UK are using e-cigarettes. Given the enormous individual and public health benefit that would flow from more smokers switching to the non-combustible product, it is important to identify what the barriers are to wider use of e-cigarettes by smokers.

As hard to believe as it might be, one of those barriers might be a misplaced assessment of how harmful e-cigarettes are compared to normal cigarettes. Both in the US and the UK there has been a worrying increase in the number of smokers who think that e-cigarettes are actually more harmful than normal cigarettes. The reason for such an erroneous view is likely to be news media headlines that repeatedly announce the harms of e-cigarette use, without comparing those harms to combustible cigarettes. It is entirely possible that some smokers are choosing not to switch to non-combustible nicotine products in the mistaken belief that to do so might actually increase their level of risk and harm.

In interviews with a sample of smokers, many of those who said that they had tried e-cigarettes but not continued with them commented that, in their view, these devices were a poor substitute for smoking. Some of the smokers said that they did not like the hard plastic feel of e-cigarettes or the feeling that vaping was 'cold' in a way in which smoking was 'warm'.

Some of the smokers were clearly confused by the vast array of e-cigarette technology and put off by the bewildering details of nicotine strengths, flavours, coils, ohms, tanks, wicks and batteries. For these smokers, the cigarette had an appealing simplicity. If you have one, you light it, and you smoke it. The comments from these smokers suggest that the technology of e-cigarettes has some way to go before these devices become attractive to the majority of smokers.

Government can initiate measures that are likely to increase e-cigarette use among smokers. These measures include ensuring that e-cigarettes are taxed at a level that makes them cheaper than combustible products. Another thing that governments can do, is to discourage the various bans on e-cigarette use that have been instituted out of a misplaced belief secondhand vaping causes harm. Public health bodies, however, need to do much better in accurately conveying to smokers the relative harms of combustible and non-combustible cigarettes, tackling the large and growing proportion of smokers who don't know, or who believe that smoking is actually safer than vaping.

There are other way in which the use of e-cigarettes can be stimulated among smokers is for 'stop smoking' services to become e-cigarette friendly. While there are some services that positively encourage e-cigarette use by smokers as a way of bolstering individuals' attempts at stopping smoking, there are other services that either frown on e-cigarettes and or ban the use of these products on their premises. Such bans contribute to stigmatising vapers and vaping, and ignore the fact that hundreds of thousands of smokers have used these devices as a way of stopping smoking.

> Some smokers are clearly confused by the vast array of e-cigarette technology... Cigarettes have an appealing simplicity. If you have one, you light it, and you smoke it...

Finally, manufacturers of e-cigarettes have an important role to play in increasing the appeal of these devices to smokers – which, ironically, may entail ensuring that the experience of vaping is closer to the experience of smoking.

Prof Neil McKeganey is at the Centre for Substance Use Research, Glasgow

Kenward Trust
transforming lives, creating new futures

2017 WINNER OVERALL

MENTAL HEALTH NURSE/ DEPUTY MANAGER

Two exciting opportunities have arisen to be part of Kent's Care Charity and Charity of the Year 2017.

If you are an innovative thinker and would relish an opportunity to shape future services, this is a chance to be part of a team that is at the forefront of residential care.

Closing date: 26th May 2017
Up to £28,000 pa dependent on experience plus pension and benefits

www.kenwardtrust.org.uk

Follow us on Twitter
Like us on Facebook

Twitter: @DDNMagazine
Facebook: DDN Magazine

Substance Misuse Personnel

Permanent • Temporary • Consultancy

Supplying experienced, trained staff:

- Commissioning
- Service Reviews
- DIP Management
- DAT Co-ordination
- Needs Assessments
- Project Management
- Group & 1-1 drug workers
- Prison & Community drug workers
- Nurses (detox, therapeutic, managers)
- many more roles...

Call today: 020 8987 6061

Register online:
www.SamRecruitment.org.uk

Solutions Action Management
Still No.1 for Recruitment and Consultancy

KINESIS LOCUM
Specialist Recruitment

- Total Recruitment for the Drug and Alcohol field. (DAAT, Nurses, Commissioning. NHS. Criminal Justice...and more)
- The Trusted Drug and Alcohol Professionals.

You call Kinesis, we do the rest!

www.kinesislocum.com

0207 637 1039

Build On Belief

We are pleased to invite applications for the following opportunity:

SERVICE MANAGER

London: Hillingdon
Hours: 37.5 hours per week • Salary: £25,000 p.a.

A rare opportunity to join a unique service user charity working with individuals who have, or have had substance use issues, Build on Belief is looking for a full-time Service Manager to help design, implement and run a wide range of peer-led activities in Hillingdon. You will recruit, train, develop and work with a growing volunteer team, as well as support the main providers in delivering a high-quality service across the partnership.

We are particularly interested in recruiting someone who has direct working, or lived experience of substance use problems.

You will work closely with the Operations Manager to develop and promote this exciting, and growing service across the London Borough of Hillingdon. The role will involve running a peer led-weekend service and the ideal candidate will be flexible, imaginative and pro-active in their approach to the job. The post will initially run for one year.

Closing date for applications: Wednesday 17th May 2017
Interviews will take place in the week beginning 22nd May 2017
Expected job start: 1st June 2017

For further information, including a job description, please email timsampey@buildonbelief.org.uk

To apply please send a C.V and covering letter to beccawalker@buildonbelief.org.uk

PUBLIC POLICY OFFICER – London

INVOLVEMENT MANAGER – Liverpool

RECOVERY WORKER – Nottinghamshire

PRISON WORKER – London

PARTNERSHIP MANAGER – Blackpool

SAFEGUARDING COORDINATOR – Oxfordshire

SUBSTANCE MISUSE NURSES – Nationwide

DEPUTY SERVICE MANAGER – Manchester

SEE THESE JOBS AND MORE AT
www.drinkanddrugsnews.com/jobs

ADVERTISE ONLINE NOW

Contact **ian@cjwellings.com**
to advertise your next vacancy