

**DRINK AND DRUGS NEWS**

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# DDN



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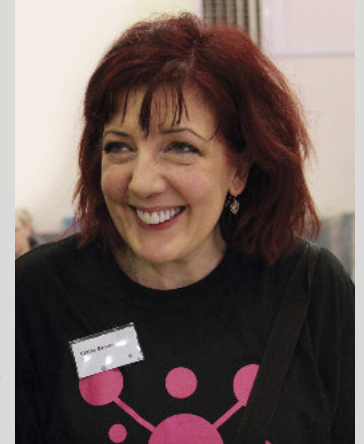
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## EDITOR'S LETTER

### 'It showed that where there's a will, things happen'



How do we get connected? With healthcare, with peers, colleagues, commissioners, policymakers, politicians? It's a question that goes far beyond the DDN conference – but the spirit of this event confirmed that where there's a will, things can happen.

On the following pages you will find not just the record of the day's events, but a host of possibilities, questions and ideas. How can we make sure the relationship between those providing and seeking healthcare is as good as it can be? How do we ensure these all-important interactions are not one dimensional, but create pathways to other vital support services and branches of healthcare? What do we do if we're not getting the treatment we need?

The crucial component in a day like this is those who come along to say 'I did it like this and it worked for me' – call it expertise by experience, service user involvement, or whatever you will. But whether it's hepatitis C treatment, supported housing, education and training, or taking part in local decision-making, the people who look back after they have tried the route are the ones who leave doors open for the rest of us.

Equally important was the emphasis on 'having your say' – PHE, commissioners and researchers all wanted service user involvement in feedback, planning and 'lived experience'. This surely must give impetus to including peer-led groups and enterprises as a standard component in every local tender.

Claire Brown, editor

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Visit our website for conference films and photos!



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## WEST MIDLANDS PCC PROPOSES CONSUMPTION ROOMS AND PRESCRIBED HEROIN

### A RANGE OF PROPOSED HARM REDUCTION MEASURES

to cut drug-related crime and deaths, and reduce costs to public services, has been set out by West Midlands police and crime commissioner (PCC) David Jamieson. They include prescribing heroin in a medical setting for people who have not responded to other forms of treatment, establishing a formal scheme to divert people away from the courts and into treatment, and 'considering the benefits' of consumption rooms.

Other measures in the PCC's report include joining up funding streams for police, public health and community safety to increase efficiency, introducing on-site drug testing in the night-time economy, and equipping and training police in the use of naloxone. More money could also be seized from large-scale drug dealers to invest in treatment, it says. Half of all burglary, theft, shoplifting and robbery in the region is thought to be committed by people with serious drug issues, at a cost of £1.4bn per year. Jamieson's announcement follows similar proposals from other PCCs including those for Durham (*DDN*, March 2017, page 4) and North Wales (*DDN*, September 2017, page 5).

'Despite the good work being done by many, collectively our approach to drugs is failing,' said Jamieson. 'It means people are forced to live with more crime, public services are put under strain and not enough is done to reduce the suffering of those who are addicted. If we are to cut crime and save lives there's one thing we can all agree on; we need fresh ideas. These are bold but practical proposals that will reduce crime, the cost to the public purse and the terrible harm caused by drugs.'

Jamieson wanted to see many of the measures 'in place and having an effect' by the end of his term of office in 2020, he said. 'I will be working with partner organisations intensively over the coming period to deliver on these practical and common-sense proposals.'

The announcement has been welcomed by organisations including Release, Transform, the Association of Police and Crime Commissioners and the Royal Society

for Public Health (RSPH). The recommendations were an 'important and welcome contribution to the growing momentum behind common sense drug policy reform in the UK', said RSPH chief executive Shirley Cramer. 'Health professionals, police, and the public are all agreed that a public health – rather than criminal justice – approach to drug policy is what is needed to tackle rising rates of drug harm in this country and beyond. It is heartening to hear more influential voices, with on the ground experience of these issues, give these measures their backing.'

The measures 'would undoubtedly save lives if implemented', added Release executive director Niamh Eastwood. 'Yet again, the police are leading the way in the debate for drug policy reform while the government continues to pursue the failed approach of prohibition and criminalisation. The government must consider the insight of police officers, many of whom are on the frontline of the so-called war on drugs, witnessing the horrific impacts that prohibition has on communities every day.'

*Read more on PCC strategies in our April issue.*



If we are to cut crime and save lives there's one thing we can all agree on; we need fresh ideas.

DAVID JAMIESON

Science and Technology. Between 189,000 and 208,000 children are thought to live with an alcohol-dependent adult, although these figures are 'likely to underestimate the scale of the issue', says *Parental alcohol misuse and children*. Available at [www.parliament.uk](http://www.parliament.uk)

## PROBLEM PRESCRIPTIONS

**NINE OUT OF TEN** areas where GPs prescribe the most opioid drugs are in the north of England, according to UCL research published in the *British Journal of General Practice*. Prescriptions are 'steadily rising', particularly in deprived communities, it states. 'We feel that the most important finding is the extremely strong association between the amount of opioids prescribed and lower socio-economic status,' said lead author Dr Luke Mordecai. 'The variation across the country is undeniable and, given the morbidity and mortality associated with this class of drugs, unacceptable.' A major independent review into the 'growing problem' of prescription drug dependency was recently launched by PHE (*DDN*, February, page 4).

*Patterns of regional variation of opioid prescribing in primary care in England at [bjgp.org](http://bjgp.org)*

## RISK/REWARD

Vaping poses 'only a small fraction' of the risks of smoking, and NHS trusts should ensure that e-cigarettes are available for sale in hospital shops, says an updated evidence review from PHE. While switching completely from cigarettes to e-cigarettes conveys 'substantial health benefits', there is widespread public misunderstanding around vaping risks, it states. 'It would be tragic if thousands of smokers who could quit with the help of an e-cigarette are being put off due to false fears about their safety,' said PHE's director for health

improvement Professor John Newton. *E-cigarettes and heated tobacco products: evidence review at [www.gov.uk](http://www.gov.uk)*



'Substantial health benefits'

PROFESSOR JOHN NEWTON

## BE BRIEF

**TARGETED TRAINING** leads to a 'significant increase' in the delivery of alcohol brief interventions in primary care, according to a study by Alcohol Research UK and SMMGP. Specifically trained nurse mentors are able to play a key role in leading and delivering interventions and brief advice (IBA), says the study, with even a 'relatively low level of support' helping to reduce alcohol-related harm within existing resources. 'The primary care team has great strengths in identifying, assessing and preventing health harms,' said lead author Dr Steve Brinksman. Supporting

nurse mentors could increase 'practical implementation of an evidence-based cost effective intervention which has experienced patchy uptake', he added. *Supporting nurse mentors to reduce the barriers to implementing alcohol interventions and brief advice in primary care at [alcoholresearchuk.org](http://alcoholresearchuk.org)*

## PARENTING MATTERS

**PARENTAL ALCOHOL MISUSE** is implicated in more than a third of cases involving the death or serious injury of a child through neglect or abuse in England, according to a cross-party report from the Parliamentary Office of

Alcohol misuse is implicated in a third of child neglect and abuse cases





# INCREASE FOCUS ON OLDER PEOPLE, ROYAL COLLEGE URGES

**SERVICES SHOULD INCREASE** their focus on older people because of the sheer number of 'baby boomers' needing help for substance misuse issues, says a report from the Royal College of Psychiatrists.

Improved training is needed at all levels, including the training of more addictions psychiatrists, says *Our invisible addicts*, an updated version of a 2011 report from the college. With most substance problems in older people 'going undetected' there is an urgent need to improve diagnosis, treatment, education, training, service development and policy, it stresses.

Older people with substance issues face a 'complex constellation of risks', the report says, which can result in presentation to a wide range of services including drug and alcohol treatment, primary care, acute hospitals, older people's mental health, social care, housing, criminal justice and the voluntary sector – in many cases 'the staff in these settings have little specialist knowledge of how to deal with such complexity', it adds.

The document calls for a multi-sector approach, improved peer support and development of a clinical workforce with the 'appropriate knowledge, skills and attitudes' to provide identification, assessment, referral and treatment – 'in particular, we see a need to reverse the loss of multi-professional specialist training in addictions that has taken place in recent years'.

While older people respond well to brief advice and motivational therapy – and in some cases can have better outcomes than younger people – there is a 'paucity of UK-based research and evidence for treatment interventions and services' around the



'[This is] a problem that is likely to increase further over coming decades.'

PROFESSOR ILANA CROME

management of substance use disorders in older people, and the population has also traditionally been under-represented in research studies. It is also vital that people not be excluded from treatment because of their age, stresses the report, which was produced by a working group of professionals across a range of clinical specialities as well as service users.

'In the 21st century, substance misuse is no longer confined to younger people,' said working group chairs Professor Ilana Crome and consultant psychiatrist Dr Tony Rao. 'The public is poorly informed about the relationship between substance misuse and health risks in older people. We need a clear and coordinated approach to address a problem that is likely to increase further over coming decades. By improving our approach to substance misuse in older people from detection to continuity of care, we can also improve both quality of life and reduce mortality in a vulnerable group that deserves better.'

*Our invisible addicts 2018 at [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)*

## DUTERTE DEEDS

**THE INTERNATIONAL CRIMINAL COURT (ICC)** – which investigates genocide and crimes against humanity – is opening a preliminary examination into the Philippines, it has announced. The examination will 'analyse crimes allegedly committed' in the context of the government's war on drugs, said the ICC's prosecutor, specifically 'extra-judicial killings in the course of police anti-drug operations'. The preliminary examination process is used to decide if there is a 'reasonable basis' to proceed with a full investigation.

## PRIMARY NUMBERS

**THERE WERE 82,135 HOSPITAL ADMISSIONS** with a primary or secondary diagnosis of drug-related mental and behavioural disorders in 2016-17, according to NHS Digital, up from 81,904 the previous year. The total is nearly double the 38,170 figure from a decade ago, although NHS Digital says this increase will be 'partly due to improvements in recording of secondary diagnoses'. The number of admissions with a primary diagnosis of drug-related mental and behavioural disorders, however, was down by 12 per cent in 2016-17, to 7,545, although that figure is still 12 per cent higher than a decade ago. 'People with both mental health and substance misuse issues can find it extremely difficult to access mental health services,' said Addaction spokesperson Karen Tyrell. *Statistics on drugs misuse, England 2018 at [digital.nhs.uk](http://digital.nhs.uk)*

## PRICING IT IN

**THE SCOTTISH GOVERNMENT** has confirmed that it will recommend the country's minimum unit price be set at 50p, following a public consultation. Minimum pricing is set to come into force on 1 May after a five-year legal battle with the drinks industry (*DDN*, December/January, page 4). Scottish Liberal Democrats leader Willie Rennie, however, has called for the price to be set at 60p to reflect factors such as the impact of inflation, which has 'eroded the value of the original minimum price during the years that this policy has been caught up in the courts'. Meanwhile, a report from the University of Sheffield's alcohol research group has found that three quarters of all alcohol drunk in Wales is consumed by less than a quarter of the population, with just 3 per cent of harmful drinkers consuming 27 per cent. Last year's Public Health (Minimum Price for Alcohol) (Wales) Bill (*DDN*, November 2017, page 4), is set to introduce minimum pricing if passed by the National Assembly for Wales.

*Research on the likely impact of and public attitudes towards a minimum unit price for alcohol in Wales at [gov.wales](http://gov.wales)*

## POTENT PERCENTAGE

**Almost 95 per cent of cannabis seized by police in 2016 was of a high potency variety, according to a report from King's College, London and GW Pharmaceuticals.** Researchers analysed almost a thousand police seizures across the country and found that 94 per cent were of strong 'skunk' sinsemilla, compared to 85 per cent in 2008 and just over half in 2005.

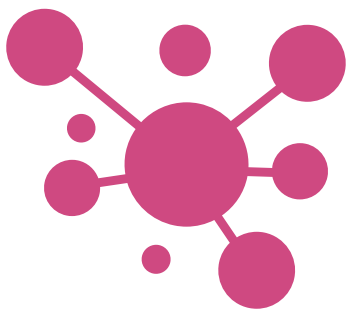
The study, published in *Drug Testing and Analysis*, found that the stronger varieties' market dominance was the result of lack of availability of weaker cannabis resin. 'The increase of high-potency cannabis on the streets poses a significant threat to users' mental health, and reduces their ability to choose more benign types,' said senior author Dr Marta DiForti. 'More attention, effort and funding should be given to public education on the different types of street cannabis and their potential hazards.' *Study at <http://onlinelibrary.wiley.com/doi/10.1002/dta.2368/abstract>*



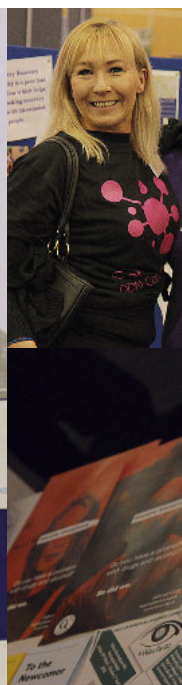
'More attention, effort and funding should be given to public education'

DR MARTA DIFORTI

After a five-year battle, Scotland confirms minimum unit pricing of 50p for alcohol



# Get Connected DDN Conference 2018 Session 1



# Healthy connections

The day's first session kicked off by looking at making effective connections with health services

**W**e've got a lot of work to do developing pathways to make sure that the health of service users is taken as seriously as that of everyone else,' CGL's director of nursing, Stacey Smith, told *Get Connected* delegates. 'We have a fantastic opportunity to make a massive impact.'

In terms of tackling hepatitis C, it was important that drug treatment services realised that they held a huge cohort of people who could benefit from testing and treatment, she said, and CGL had launched its own successful hepatitis C strategy to reduce the number of service users who become ill or die prematurely as a result of hep C infection. 'We have current and previous injectors in our system, and the treatment landscape has significantly improved for drug users with hepatitis C. It's a two-way process – we need to work with the NHS, and they need to work with us. If we can match up people's drug treatment with their hepatitis C treatment, think of the fantastic things we can do.'

Drug services held enormous amounts of invaluable data, she told the conference. 'That's data about people who may have been diagnosed ten or 15 years ago, as well as data on people coming in now.' Where previously hepatitis C treatment had been 'painful, hard, long and not always successful', that was no longer the case, and it was vital to make sure that service users were aware of this. 'We need to let people know that it's not about interferon any more. Wouldn't it be fantastic if every service user who walked into a drug service demanded to be tested and treated?'

Services were perfectly placed to play a crucial role in the drive towards the complete



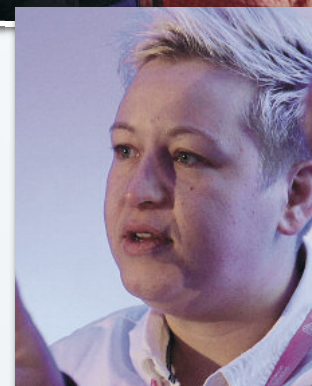
**'Universal credit has made it very hard to access housing.'**

STACEY SMITH

eradication of hepatitis C, she said, and were also equipped with vital skills in areas like motivational interviewing and contingency management. 'We know there are people out there who are still injecting, so we need proper use of harm reduction. We need to look at re-engaging with needle exchanges and talking about what harm reduction really means.' Key to this were areas such as optimum prescribing, the development of evidence-based models with treatment on site, and proactive partnerships with bodies like the Hepatitis C Trust, the NHS and service user groups.

'We have it within our capability to eliminate hepatitis C within drug and alcohol services,' she told delegates, and CGL now had four models running across the country that matched up people's treatment and prescriptions. 'Let's get innovative – whichever way works for you, do it. The opportunity we have now is massive.'

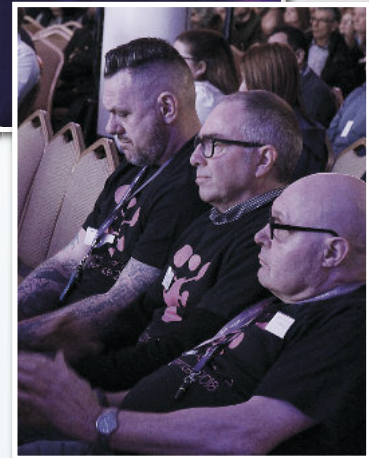
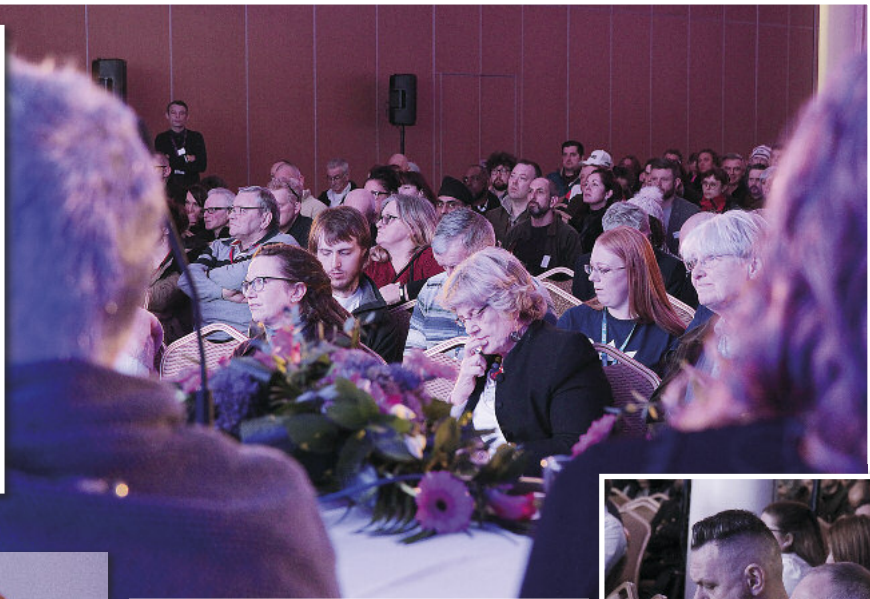
**R**ecovery champion Alesha Watkins told the conference how she had initially been offered testing and treatment after accessing a needle exchange in Northamptonshire in 2009. 'A couple of weeks later I was advised I had hep C, but I wasn't ready to engage,' she said. She continued to inject,



**'After seven years of having hepatitis C, I stand here today free of any virus.'**

ALESHA WATKINS





including on occasion sharing needles and equipment, but later – when in a more stable situation – she started to ‘understand the long-term implications’ of living with the virus.

She began treatment with interferon, but experienced a range of unpleasant side effects, the worst of which was the profound effect on her mental health. ‘I had extreme mood swings, hallucinations, suicidal thoughts,’ she told the conference. ‘The treatment was painful and took a huge toll on my body.’

However, thanks to connecting with a new consultant, in 2016 she was approved for the recently launched 12-week treatment programme using oral medication. ‘There were no injections and no physical or mental side effects. After seven years of having hepatitis C I stand here today free of any virus, and my future is as bright as it’s ever looked.’



**‘You have to take healthcare out on to the street.’**

SUE MCCUTCHEON

**T**he session then moved on to looking at connecting those populations traditionally be seen as ‘hard to reach’ with effective healthcare, and heard from Sue McCutcheon, an advanced nurse practitioner with

the homeless primary care team in Birmingham. ‘The people I encounter have multiple significant health concerns,’ she told delegates. These included liver disease, respiratory problems, infections and mental health issues, while problems that could affect anyone, such as epilepsy or diabetes, were obviously far more difficult to manage for people who were both homeless and had substance use issues.

Many clients had an intense mistrust of services, which meant that they tended to present very late in the pattern of illness, she said, often ‘at the point where it’s life-threatening,’ while some would not even present then. ‘They have different

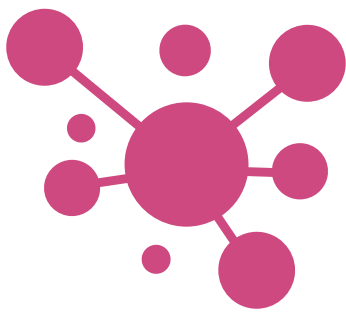
priorities, as well as concerns about being admitted to hospital if they’re not on OST. So it’s about working with that – sitting down with the client and getting a plan together, and supporting them in realising that goal of accessing health care.’ She would offer to take people to hospital herself, she said, acting as an advocate and staying with them until they had been prescribed methadone. ‘But obviously I shouldn’t have to do that,’ she said.

One frequently quoted reason for not accessing services was that there was nothing for synthetic cannabinoids such as ‘mamba’, she pointed out. ‘Or people might say “I want a script today, not in two weeks,” or “I need a detox now, not in four months.”’

Some of the most entrenched individuals were not on benefits and not accessing healthcare, although they had the highest levels of need, she said. ‘So you have to take healthcare out on to the street – attending to their immediate health needs, supporting them to attend GP, nurse and hospital appointments, referring them to hospital specialists and giving them naloxone training. The highest percentage of people dying through overdose are those not accessing services, so that training can be vital.’

It was also important not to overlook wider screening, she stressed, whether blood pressure, breast, or BMI checks, or cervical smears, ECGs or vaccinations. ‘The whole point of screening is to pick up things early, and oral health checks are also important. We know that alcohol and smoking raise the risk of mouth cancer but many of these clients won’t have seen a dentist in five or ten years, or longer.’ Other issues faced by her clients included respiratory problems such as COPD, emphysema or TB, infections linked to street injecting and sepsis, which carried ‘a real risk of death but which is an easy diagnosis to miss because the symptoms can be so vague’. The risk of infection could be reduced by clean kit, good lighting, a clean and





# Get Connected DDN Conference 2018 Session 1



warm environment and dignity and privacy, such as could be provided in a consumption room.

The aim of her team was 'fundamentally about keeping people alive and avoiding disability', she told the conference. 'We want people to stay as healthy as possible whether or not they're accessing drug treatment services.'

**N**ext up was service user advocate Nick Goldstein, on the importance of getting the right connection between pharmacist and patient. As someone actively involved in pharmacists' training to help raise awareness of the reality faced by service users (*DDN*, March 2017, page 12), he stressed that the pharmacists being trained were usually 'quite young and open to ideas, and they've also got long careers ahead of them, so they can spread the message to others as well'.

As he was only given a 30-minute time-slot with the trainees he needed to 'boil it down to two main themes', he said – humanity and identity. 'In terms of the first, I did that by talking about myself, my family and friends, my hopes, dreams, fears and woes, to show I was a person rather than a label.' Reinforcing the second theme was important to 'show that we're individuals', he told the conference. 'My request is simply that I want to be treated like anyone else, like someone who comes in for any other prescription.'

'In time the questions like "are you on drugs now?" stop and they become things like "what can we do for you and your community?"' he continued. 'And the tone noticeably changes as well. It shows that proper communication is vital to any therapeutic relationship.'



## 'Getting the right connection between pharmacist and patient.'

NICK GOLDSTEIN



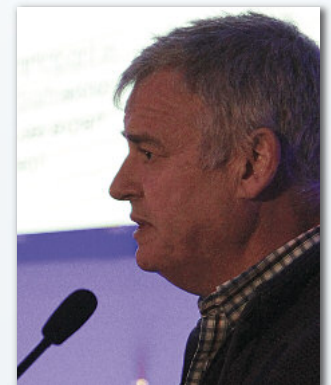
enormously. 'There's also their medical knowledge and knowledge of the patient, their family and community to consider, alongside personality, age, gender and ethnicity. 'Added to this were external factors like time availability, workload pressure, policy, finance and the influence of third parties. 'I'm afraid we can be constrained by some of these things,' he said.

'It's essential for both parties to be honest about what they want to achieve. Sometimes there's a tendency on both sides to tell the other person what you think they want to hear. Be honest, be on time, be open about what you want to achieve and behave appropriately. If you're in the surgery surrounded by little children and little old grannies it's important that your behaviour fits into that situation. But at the same time, doctors have to be honest, give you time and treat everyone the same,' he said.

Doctors also had a duty to provide information in a way that could be easily understood and that was backed up by evidence, he said. 'It's not my choice how you define your ongoing treatment, but if we can do these things together we can start to work towards that mutual respect that will make a huge long-term difference.' **DDN**

two were sometimes necessary, 'we need to be moving towards mutual participation', he said. 'I might not always agree with your decisions, but they are your decisions.'

It was vital that patients and service users were empowered to ask for the right information to inform these decisions, he stressed. 'The relationship between practitioner and patient can be a key element in any progress made, as much as the medication.' Key things to consider about patients were their concerns and expectations, knowledge, attitude, personality, age, gender and ethnicity, he said, while the attitudes and values of doctors could also vary



## 'There are now far more GPs willing to work with drug users.'

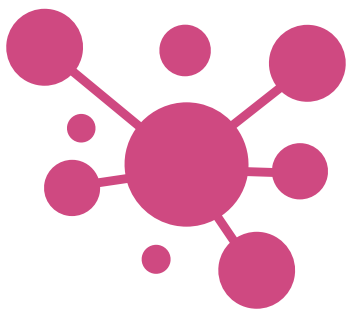
DR STEVE BRINKSMAN

**C**losing the first session was Birmingham GP and *DDN Post-Its From Practice* columnist Dr Steve Brinksmann, on ensuring proper connections between doctor and patient. 'In 27 years of being a GP, one of the things I'm most pleased about is that there are now far more GPs who are willing to work with drug users,' he said. 'Things can change, and you can change people's perceptions.'

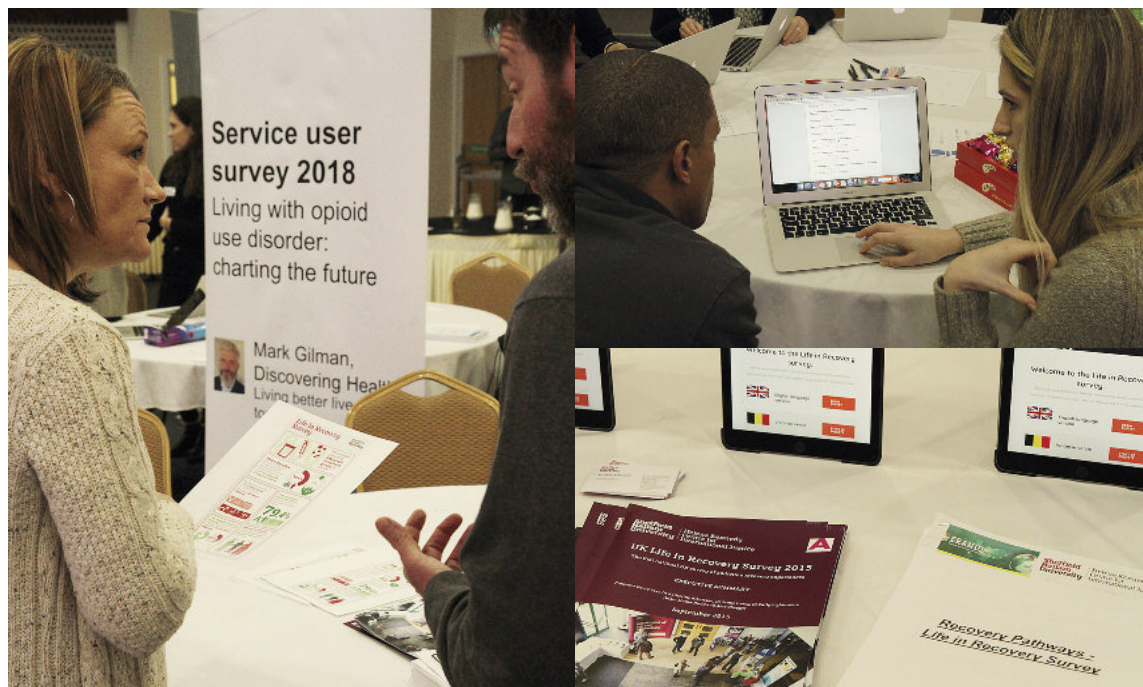
There were issues of perception on both sides, however. 'I'm not going to stand here and say that every engagement with every health professional will be perfect. People like me can seem scary and bossy to you, but a lot of doctors might be as frightened as you are – remember, they haven't been taught about these things in medical school.'

There were three basic models of doctor/patient relationship, he said – active/passive, guidance and cooperation, and mutual participation. While the first





## Get Connected DDN Conference 2018 Surveys



# Connecting through experience

DDN welcomed two research teams to 'Get Connected', to carry out their surveys in the exhibition area throughout the day. Here each team explains their project's aims

### HOW DO YOU RECOVER?

An international collaboration, led by Sheffield Hallam University and funded by the National Institute for Health Research, is undertaking a longitudinal study on recovery pathways and societal responses. Called REC-PATH, the project will assess pathways to addiction recovery in England, Scotland, Netherlands and Belgium.

We were pleased to attend the *DDN Get Connected* conference and meet many incredibly strong and brave people in recovery and service providers supporting them. We are delighted with *DDN's* support and the partnership that is characteristic of work in this area.

Recovery in the UK has been a dominant policy since 2010, and we have witnessed many successes along the road so far. Yet, recovery orientated policies and practices in non-English speaking countries have only recently been introduced and have not been fully implemented. Our study attempts to assess 'structural' variations in recovery policy and practice, comparing the UK with the Netherlands and Belgium – countries only beginning to embed a recovery model in substance use policy.

The aim is to better understand the impact of UK recovery policy and the early impact of recovery policy in the Netherlands and Belgium by looking at recovery orientated strategies and interventions individuals are engaging with, while addressing more universal questions about mechanisms of behaviour change and life course transitions.

We know from the evidence that 58 per cent of people with addiction do recover. Less clear are what mechanisms of change promote recovery in women and in men, and what role policy has on recovery pathways.

Our project uses a life-course method to understand what recovery approaches have been beneficial to individuals in different stages of recovery: early (less than one year); sustained (one to five years); and stable (five years and more).

From the participants completing the Life in Recovery survey, we will recruit 150 people (fifty in each stage of recovery) in each country. Participants will be

interviewed on two occasions, at baseline and one-year follow-up, with 30 recruited for an in-depth interview at the one-year follow-up. The aim is to assess the role of five Mechanisms Of Behaviour Change for Recovery (MOBCR) and their impact at different stages in the addiction/recovery career.

The MOBCRs are:

- i. natural recovery
- ii. 12-step mutual aid
- iii. peer-based recovery support
- iv. residential treatment
- v. specialist community treatment

We would like to invite you to help build our understanding of how people recover. This is critical to improving recovery policy and practice. Together with people who have overcome an addiction problem, we want to show that recovery from addiction is possible. We want to find out more about your recovery, because sharing your experiences can help other people with an addiction.

**Please join the recovery community and visit [www.rec-path.co.uk](http://www.rec-path.co.uk) for more information about REC-PATH and to complete the Life in Recovery survey.**

### YOUR SAY IN SHAPING TREATMENT SERVICES

The Expert Faculty on Commissioning asked about experiences of treatment for problematic opioid use to inform future care planning.

The approach to care for people with drug problems or problematic opioid use has improved greatly – progress based on adopting new approaches and innovation. In the future, understanding the views of service users and people in recovery is important in making decisions about care.

Results of a survey of the 'lived experience' of the drug treatment services are now available. The survey was run by Mark Gilman, former recovery lead at Public Health England, and is the third assessment of the opinions of people involved in this area.

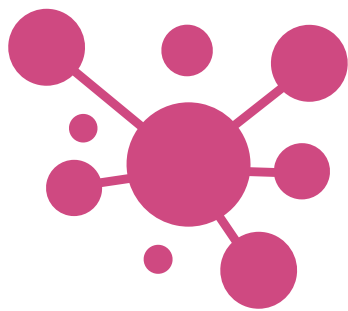
Responses highlighted a need for greater patient input in development of personal treatment plans as well as in wider decisions on service provision. Only 33 per cent of participants felt treatment services provide them with choice tailored to their individual needs and goals, while just 26 per cent stated there was effective representation of patient or service user voices in national decisions about care.

The survey highlights that service users and people in recovery are keen to participate in the discussion and planning for the future of treatment.

Lived experience should inform the future of innovative care for people with problematic opioid use. Let us connect the service users and the people in recovery to the decision-makers and build on what we have, to make future services even better.

**Detailed results of the 2018 annual survey will be presented at the congress of the Expert Faculty on Commissioning (EXCO) on 22 June in Manchester. More information at [www.expertfaculty.org](http://www.expertfaculty.org)**

'We would like to invite you to help build our understanding of how people recover.'



## Get Connected DDN Conference 2018 Session 2



# Connecting the dots

The day's second session focused on making the right connections between service users and housing, service users and commissioners, and properly connecting up data to get a true picture of what was happening on the ground

Session two kicked off with a presentation from Phoenix Futures' housing provision team, on how supported housing can make the right connections for people moving towards recovery. The 50-year-old charity provided services for more than 20,000 people a year and was also housing association, Vicky Ball told delegates. It currently had 150 rehab beds and 185 supported bed spaces across England and Scotland. 'We own some properties, lease some from other landlords and manage properties for other agencies.'

Opiate users were generally people with very high levels of housing need, she said. 'The advent of universal credit has made it very hard for this stigmatised group to access housing. Local authorities spend around £800m a year on drug and alcohol treatment, but if people come out of treatment with somewhere to live they're much more likely to sustain their recovery.'

'In residential services we identified that people were struggling when they went out into the community because of a lack of suitable accommodation post-treatment,' said her colleague James Graham. In response the organisation had developed an approach that included supported housing, recovery housing and independent living properties, he said.

Supported housing provided a safe environment for people who had just left treatment, with high levels of staff input. 'There's support planning, guidance, advice,

signposting, advocacy, and lots of peer support and partner provider involvement.' Recovery housing, meanwhile, had less input from staff as 'by this point people are generally getting on with their lives in the community and have found a direction. But staff are always there if they need them.' And finally with independent living, Phoenix were 'basically just their landlords', he explained. This approach provided a safe environment for people to develop all aspects of recovery capital and give them an opportunity to explore their future goals and aspirations, he said. 'When people come off drugs it can leave a big void in their lives.'

Service user Julie Hobson told the session how she had come to Phoenix with a serious alcohol problem that had involved homelessness, domestic violence and multiple stays in hospital, and was allocated supported housing. 'I had a housing support worker who helped me, and that gave me a stable environment,' she said.

She now had a job and was volunteering as a peer mentor, while Phoenix had also helped her re-engage with her family. After 11 months she'd moved from the core housing provision to shared accommodation with two other people – 'the support is still there but we have a little bit more independence'. A support worker was on-hand to help with areas such as benefits and community involvement, and she would be moving on to the independent living stage in the near future, she told the conference.



'Providing a safe environment for people to develop all aspects of recovery and give them an opportunity to

explore future goals.'

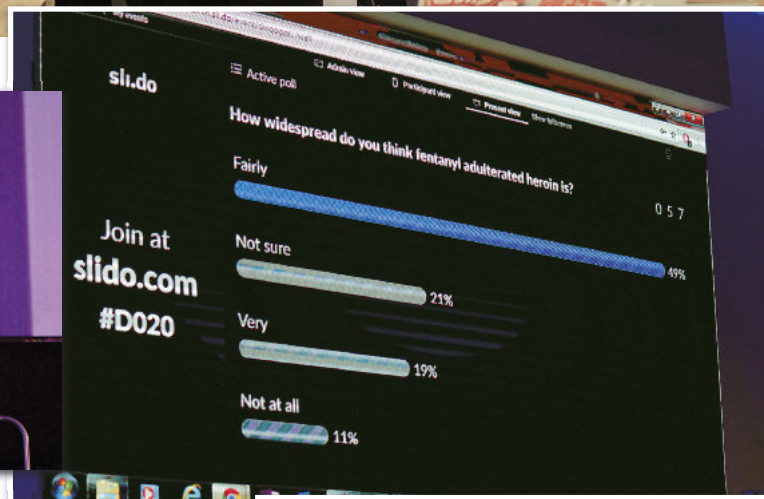
JULIE HOBSON, JAMES GRAHAM (TOP) AND VICKY BALL OF PHOENIX FUTURES' HOUSING PROVISION TEAM





**N**ext it was the turn of Pete Burkinshaw and Brian Eastwood from Public Health England (PHE), on making the right connections between data and service users' experience. 'We wanted to do something a bit different this year. We wanted to hear from you,' said Burkinshaw. 'Fundamentally you know a lot more about what's going on than we do as civil servants sitting in Whitehall.'

PHE had been stepping up its surveillance through mechanisms such as Report Illicit Drug Reactions (RIDR), as drug use was currently in a 'dynamic phase'. While the long-term trend was still one of declining rates of use, the agency was still seeing 'upticks in certain things', he said. 'What we do with a lot of that data is summarise things that clinicians



should be aware of.' The agency ran a quarterly forum on health harms to explore shifts and changes, and used this data to help inform local decision making. It was also working to improve local drug alert systems, he said.

'Often there's a lot of poor information, re-circulated, so we're looking to improve that,' he told delegates. PHE also issued alerts on issues such as fentanyl, synthetic cannabinoids and the monitoring of HIV and hepatitis C, and provided an annual data pack to local authorities around drug treatment statistics. 'We are increasingly data-rich, and if it's good and robust hopefully it becomes an important part of local decision making in this increasingly devolved environment,' he said.

Eastwood then took over for an interactive exercise that allowed delegates to answer a series of questions using their smartphones. On the subject of whether they were aware of an increase in crack use in their area, 39 per cent were not while 20 per cent said there was a



**'We want to hear from you.'**  
PETE BURKINSHAW

large increase and 16 per cent said there was no increase. On the question of whether they thought crack had become more easily available, around three quarters said yes, 24 per cent were not sure and just 2 per cent said no.

Most people (80 per cent) that delegates had contact with bought crack via a dealer, while 11 per cent bought it via a partner or friend, while 47 per cent were aware of increasing numbers of young people using crack and heroin for the first time and 35 per cent were not. Just under half of delegates thought fentanyl-adulterated heroin was now fairly widespread, and 24 per cent were aware of people actively seeking out fentanyl.

Accurately mapping trends in opiate and crack prevalence relied on a large number of data sets, said Burkinshaw – from the police, prisons, drug treatment – which meant there could often be a significant time lag. 'It's always a few years

behind, but certainly there's a trend of declining heroin use – although that decline seems to be slowing down. We're confident that the decrease has stalled, and we are seeing an increase in crack use, particularly in areas like Eastern England and the South West. Data can sometimes do funny things, but we are concerned that this data reflects reality.'

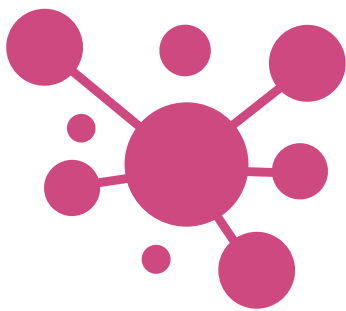
While there had generally been a fall in presentations for most substances, there were increases among two distinct populations, he explained – first-time crack presentations, and people using crack alongside heroin. These also had a different age profile, with those presenting for crack use alone tending to be younger while those using crack alongside heroin were likely to be in their 40s. 'We're particularly concerned about those younger cohorts,' he said.

Another concern was that numbers in alcohol treatment were declining faster than those in drug treatment. 'That's worrying because the treatment penetration rates are much lower for alcohol,' he said. 'It's a significant cause of concern for us, and we're having conversations with all the directors of public health about why this is happening. It raises lots of questions about the type and nature of provision and perhaps the priority alcohol is being given in local areas.'

While NPS use was declining at a general population level, it was becoming more acutely concentrated in marginalised and vulnerable populations such as the homeless and prisoners, he continued. 'The alarming increase in drug-related deaths has been with us for about four years now, and we're also concerned about fentanyl. The rate at which drugs are being synthesized is changing, and more and more people are buying them on the dark web. We're at a heightened state of alert, but so far we're not seeing fentanyl use spiral out of control.'







# Get Connected DDN Conference 2018 Session 2



**N**ext the conference heard from representatives of the newly formed Faculty of Commissioning (*DDN*, February, page 10). 'We're genuinely interested in listening to you,' the faculty's Mark Gilman told delegates. 'Commissioning is the design of services, and the primary reason for establishing the faculty was to get your input. In the past, you could argue, the service user voice has always been mediated through providers. I'm convinced that it should be heard directly.' Another key purpose of the faculty was to look at whether 'what we're doing with the money we've got left is the best we can be doing,' he stressed.

'The bottom line about all these new treatments and innovations is that they'll either cost money or save money,' said Terry Pearson. 'So we need to hear from you about whether they're effective.' The faculty aimed to



**'The service-user voice should be heard directly.'**

MARK GILMAN

improve treatment, but that was 'not the common picture', he said, as all too often providers were held to contracts that severely restricted innovation.

'For me, it's about choice,' Paul Musgrave told the session. 'As commissioners we need to have that link with service users. There's a potential system packed with choices, but as service users you'd probably tell us that you see fewer of them. This is not tokenistic, whatever you may have experienced in the past. Find out who your local commissioner is, and let's bring some new thinking in – we used to think the world was flat.'



**'It's about choice. Find out who your local commissioner is, and let's bring some new thinking in.'**

TERRY PEARSON AND  
PAUL MUSGRAVE



**K**errie Hudson told the session how she'd been a heroin user for 15 years and

her 'only choice' in terms of treatment had been methadone. 'I used to go to work with the full intention of using drugs when I finished, and methadone wasn't for me. I wanted to go to work, take my children on holiday, go on family days out, and you can't go with the flow of life because everything centres around the chemist's.'

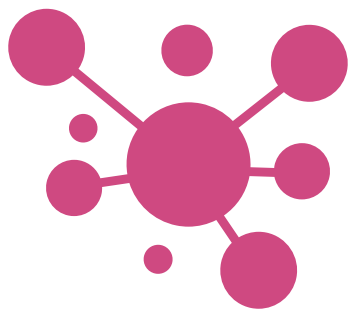
However, things changed when a forward thinking drug worker offered her subutex. 'I was staying within a 30ml limit of methadone, which started to open up choices – and one of those was subutex,' she said. 'Getting that choice opened my world – I could think, I could feel. I'd left school a heroin addict but I still had those hopes, those aspirations, and subutex gave me the clarity to go to university. We all need support, and quite often we have to do things for ourselves. We need to remove this hierarchy from recovery – it's great to be involved with the faculty and to get a direct line to the people who create our services. No one ever asked me what I needed, and this has given me that voice.' **DDN**



**'We need to remove hierarchy from recovery.'**

KERRIE HUDSON





## Get Connected DDN Conference 2018 Session 3



# The right connections

The afternoon session focused on reaching out to connect with people in need, wherever they happen to be

**W**e tend to provide support for people almost everywhere, except in education,' Dot Turton of the Middlesbrough-based peer-led Recovery Connections charity told delegates. Shame, stigma and a traditionally hedonistic culture meant that higher education could be a high-risk environment for people in recovery, she said. 'Studying is stressful and the environment can be "recovery-hostile", which means that students in recovery may keep their status a secret. If they do choose to disclose, their peer group might look at them differently.'

While the social scene in higher education inevitably revolved around alcohol, and there was also significant drug use, universities were not geared up to offer specialist, meaningful support, she said, which had led to the development of the 'collegiate recovery' model – a support structure and peer community in a college or university setting.

She'd had a chance to study collegiate recovery first hand on a six-week placement in the US, she told the conference. Typical components included physical facilities like drop-in spaces, full-time dedicated staff and professional counselling by treatment specialists, she explained, alongside on-campus meetings, 12-step provision and substance-free social events. 'But the big thing that students really valued was sober housing. That was a real safety net – they weren't in halls where their peers were coming in under the influence, and it allowed them to create that safe space.'

The university or college benefited through 'improved student performance, retention of students, peer support for students who are struggling and a positive community of role models,' she said, while the community became more 'recovery-ready', helping to reduce stigma and increase awareness. 'Bringing real, long-term recovery capital together with young people in early recovery is really beautiful and powerful to watch,' she stated, and on her return from the US she'd set about trying to replicate the model in the



**'Sober housing is a real safety net.'**

DOT TURTON

North East. 'I was determined that we should be doing more for young people in universities, because they often drop out through lack of support.'

Her organisation was now working closely with Texas Tech and Virginia Commonwealth universities in the US to try to replicate the model, she said. There was an early development of a collegiate recovery pilot, as well as a sober society at Teesside University, and she'd also helped to develop a young person's recovery forum along with recovery support and aftercare for people under 25 who were leaving treatment. 'But these things don't happen overnight,' she said. 'Some of the US facilities have been in place for 30 years.'

'For us as a recovery movement in the UK, let's look broader and try to do something a little bit different,' she continued. 'There are lots of collegiate recovery resources and papers online if you're interested. Think about your local area and if there's something that could work for you.'

**N**ext up were Ben Parker and Chris Campbell from London-based Arch, on the importance of making the connection with people in their own homes. The organisation's Emerald Pathway initiative was a targeted approach to support older alcohol users to make positive changes to their lives, delegates heard, as drinking at increasing levels of risk was most common in the 55-64 age range.

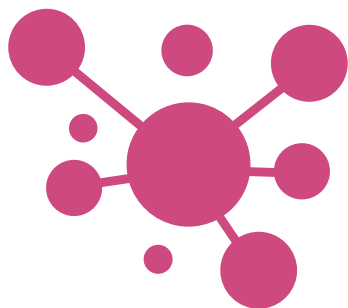
'People are often presenting at A&E with alcohol-related injuries and conditions, but they're reluctant to engage with treatment,' said Chris Campbell. 'We developed an offer of a fixed number of interventions, delivered in the home, for people over 55 or with poor mobility.'

The project had deliberately been given a name that didn't include any reference to age, he said, so as not to put people off, while the referral pathway came from A&E alcohol liaison as well as housing, GPs, adult social services and some self-referrals. The aim was to provide a set number of motivational brief interventions, explained Ben Parker, along with education, goal setting and encouraging clients to keep an alcohol diary. 'We can also work closely with family members or carers,' he said.

The initiative also included regular liaison with other healthcare professionals, and the use of wellbeing goals such as reconnecting with family, being more active and encouraging people to become more mindful of simple things that gave them pleasure. Good links with A&E were key, he stressed – 'we couldn't have done it without them. We also learned that these things take a long time and that it's very important to make that investment in family and carers.'

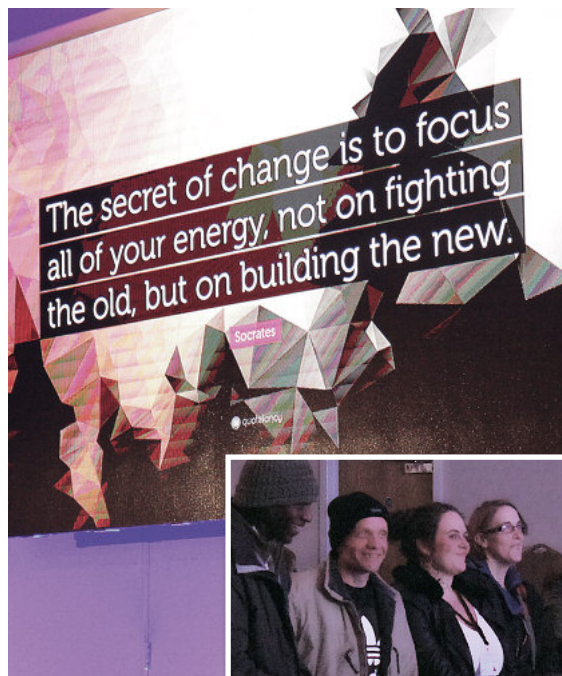
The first year had seen 'fantastic' outcomes, said Campbell, with a successful completion rate of 77 per cent compared to a national average of around 40 per cent.

'When dealing with the older generation there can be a bit of ambivalence there,' said Parker. 'People will sometimes say things like "there's no point in stopping drinking – I'll be gone in a couple of years anyway"'. You just need to say "but I want to improve your quality of life". Having patience is key.' **DDN**



Get Connected  
DDN Conference 2018

## Session 4



# Connecting to the future

The day closed with an inspirational presentation by Sunny Dhadley of SUIT and the Recovery Foundation CIC, on harnessing your potential and following your dreams

I can remember coming to a *DDN* conference for the first time about a decade ago, not long out of detox,' Sunny Dhadley told delegates. 'I didn't understand that this world existed.'

He'd been involved in problematic drug use for around 12 years, he said, which consisted of 'treatment journeys, getting fired from various jobs, and many things that perhaps I'm not proud of today'. His first battle to become empowered was when he went to his local treatment service to ask for a detox. 'They said, "who told you that you could detox?"', as if I was asking for something that had never been heard of before. Without realising it, that was my first bit of activism because I told them "actually, I really want this detox – I don't want to keep going back to the pharmacy."

He carried out a community detox 'with drug dealers knocking on the door wanting their money back' a week before he got married, and when he was discharged from treatment he was effectively told, 'go and live the rest of your life now', he said. 'But what they didn't understand was that I didn't know what life was.'

Looking around for things to connect to, he began attending NA groups and counselling and started to rebuild his fractured relationships. 'I didn't really have any formal qualifications or a career to fall back on, so volunteering for me was a way of finding out who I was.' He also re-engaged with education and found that, rather than qualifications, the key benefit was 'the confidence that came from starting something and finishing it – other than breaking the law.'

He had a desire to give something back but didn't know how that could manifest itself, he told the conference. 'The next phase of my journey was around strategic exposure. The word strategy scared the shit out of me because I didn't know what it meant.' He was volunteering locally and started asking questions, 'the same way a child would – "why, what does that mean, how does that fit into that?"' I'm sure it annoyed them, but it started to give me a picture of how commissioning worked, how targets were set, the effect of policy. It's very easy to turn your back on something if

you don't understand it, but I had an emotional connection – this was something I cared about.'

After a while it began to make sense to him within the context of his own journey and things started to fall into place. 'For me it was a massive process of empowerment,' he said. 'All of a sudden I had a budget and responsibilities for recruitment and volunteering, which made me laugh because not long before that I couldn't manage a budget of £10 in my pocket. But I persevered.'

He started building a vision in terms of what he felt was needed locally and gaining credibility with 'people I'd never met'. In 2016-17, while his Wolverhampton-based peer-led organisation SUIT received just 2.4 per cent of the local drug and alcohol budget, it supported more than 1,000 people and delivered almost 5,500 interventions across more than 70 areas of need. 'We'd never push a direction on someone, we let them lead that.' Each intervention cost just £24.74, he stressed. 'That's for supporting someone into housing from being homeless, for finding someone work, for keeping someone out of prison. It demonstrates that we don't have to wait for someone else to do this stuff, we can do it ourselves.'

In terms of influencing change, it was vital to have a clear vision of what you wanted to achieve, he said. 'The people that are going to drive change are us – people in the community. Ask questions, be that annoying little kid.' Patience and resilience were also essential, he said. 'We might see small pockets of change, and we have to celebrate that. It's about not putting people on pedestals – it's seeing everyone as equally important.'

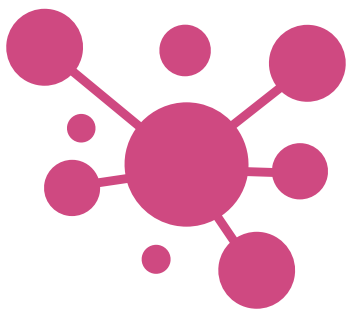
In 2014 his volunteer programme received the Queen's Award for Voluntary Service, and he went from local to regional to national meetings. He sat on the cross-party parliamentary group for alcohol, drugs and justice, while SUIT had been cited as an international model of best practice. He was also a fellow of the RSA, had been named CMI regional chartered manager of the year, and was taking part in a parliamentary initiative to encourage more people from the BME community to get involved in politics, among many other activities.

'I'm just standing up here to say this is my journey,' he told the conference. 'We all have our individual journeys, and the only person that's going to stop you from achieving the things you want to is yourself. Don't let anyone say you can't achieve things. Be proactive, put yourself into situations where you feel uncomfortable, because you'll learn from that.'

'A few years ago even the thought of standing up here would have had me quaking in my boots, but if you're championing something you believe in, you'll do anything to make it happen. There's so much energy and potential in every one of us, and there's nothing to stop you from doing your own thing.' **DDN**

'There's so much energy and potential in every one of us..!'





## Get Connected DDN Conference 2018 Therapy



# Get connected with yourself

Once again we were lucky to have Lois Skilleter and Sam Lofthouse offering therapy taster sessions at the DDN conference. Here Lois offers some self-help tips

**G**et connected: what a great theme for a conference! Networking and support groups are invaluable ways to build our confidence and meet like-minded people – and getting connected with ourselves is another very valid interpretation of this theme. Learning to know yourself, to be able to read physical, mental and emotional ‘symptoms’ and to work out what our body/mind/spirit is trying to tell us, is a really important aspect of living a fulfilling life. Being able to help yourself is so empowering, so here are a few self-help tips to help with some of the common issues we as therapists encounter so often.

Meditation and mindfulness are really ‘in’ at the moment, and for good reasons – they’re an excellent way to deal with stress and anxiety. Mindfulness is simply a form of meditation in which we stay ‘in the moment’, recognising that the past is over and done with, and the future has not happened yet. The only time we have is the ‘now’, and that is where we need to try to live. So to help you to be in the moment:

Mindfulness is simply a form of meditation in which we stay ‘in the moment’.

- **STOP WHAT YOU’RE DOING.** Close your eyes and take a deep breath, being aware of the cold air entering your nostrils and the movement of your chest and abdomen as the breath moves down into your body. Pause for a few seconds, then exhale slowly, being aware of the warm air leaving your nostrils. Keep your focus on the breath: If a thought comes into your mind, notice it and then let it go. Continue for a few more breaths and notice how you feel.
- **LOOK AROUND YOU.** Don’t engage with anything but just make a mental note of what you see. Now close your eyes, and check what sounds you can hear around you, including the sound of your own breathing. Move your awareness to your sense of touch; now your sense of smell; and finally, your sense of taste.
- **TRY AND MAKE SMALL EVERYDAY TASKS MINDFUL.** So for instance, when washing up, how does the water feel on your hands? Listen to the sound of the tap running and look at the patterns the water makes.

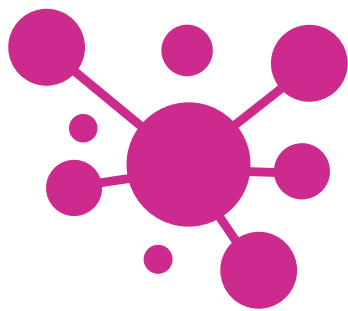
Massage and acupressure can be used to help with various minor discomforts and to support your everyday life. Being able to ease discomfort is a useful skill to have and can empower you to help yourself.

- **FOR A HEADACHE:** sit still and breathe deeply. Place the middle fingers on the occipital ridge (base of skull) behind your ears. Make small circles along the ridge, working in towards the spine, then back out. Next, bring your middle fingers to the inner edges of your eyebrows, just to the sides of the top of your nose. Press both sides at once, working up the forehead towards the hairline, and repeat across the whole forehead. Gently but firmly, circle the eye sockets, both sides together, out from these points, pressing hard and pulling firmly across the forehead, then gently down the outside of the eye sockets, under the eyes, and back up the sides of the nose. Repeat three to six times.
- **FOR INSOMNIA:** place your middle fingers on your neck, either side of the spine, about a centimetre from the bone and a couple of finger widths down from the base of the skull. Press in gently and rotate the fingertips for about 20 seconds, or just hold without rotating.  
You can also try acupressure on your ankle. Hold the ankle with the thumb on the inside, just under the prominent anklebone, and the middle finger on the outside just under the bone. Hold this position while breathing deeply for a few minutes.
- **FOR DEPRESSION:** place your middle fingers on the base of your skull, either side of the spine, and move them outwards to the hollows about halfway along. Circle these points and hold for up to 30 seconds.
- **FOR ANXIETY AND STRESS:** the headache massage can be effective for these conditions too. Ear massage is very relaxing – take the ears between the finger and thumb of each hand, and gently circle, rub and pull the ears. There are many energy points in the ears and this helps to stimulate and balance them.  
The point between thumb and index finger is a helpful one for stress – place your thumb next to your index finger and see the muscle raised between them. Gently circle the highest point of the muscle with thumb or finger for a minute or so.

Please note that these are suggestions only, based on traditional use. Always see your doctor if you have any concerns about your health.

And finally – why not connect with a massage/reiki/reflexology practitioner in your area and treat yourself or your service users? Even a short treatment can be of great benefit for relaxation and relief of stress and anxiety – ask our happy clients from the conference!

**Lois Skilleter is a therapy tutor and is happy to discuss ideas for offering therapies to groups. Get in touch via her website [www.earttherealofyorkshire.co.uk](http://www.earttherealofyorkshire.co.uk)**



Get Connected  
DDN Conference 2018

OST



# One size fits nobody

With much anecdotal evidence that people are losing their OST of choice, a meeting was held at the DDN conference to ask, 'are you getting what you want?' The comments suggest new action points for services

**D**rug-related death statistics are well documented and at their highest level since records began. Evidence also tells us that opioid substitution treatment (OST) is protective against opioid deaths, when given at the right dose and for the right duration.

At the DDN conference we took the opportunity to run an interactive session with people in treatment, those who were thinking about it, and others who had experienced it for better or worse. In an informal group, Dr Chris Ford and Stuart Haste invited people to comment on their situation. Could this help to shed light on a lost connection between services and those whose lives – and quality of life – depended on them?

It was clear from the outset that the dwindling state of funding was affecting each group of participants, with many people being told that choice of OST was no longer an option because of cuts: 'I really wanted to try buprenorphine, as I'd tried methadone twice before. But the worker said I couldn't have it because it wasn't right for me and too expensive,' said one member of the group.

Others were having their dose of OST reduced without their consent, leading to them becoming unstable. In John's case an abstinence agenda was being used as 'law' to reduce his medication: 'My prescription keeps me alive, and I've been on it for a good 12 years,' he said. 'But they keep saying I need to reduce – that it's the law. I know it isn't, but I have to fight at each appointment. The new staff don't understand, or believe in, harm reduction – but I've seen too many friends die when they stop treatment and I've got to live to bring up my kid.'

For those trying to access OST, either

**'If you don't want to listen, tell me what you want to hear.'**

**'I knew they were wrong.'**

**'I have had six key workers in the last six months.'**

for the first time or after a break in treatment, new barriers had appeared.

'I had to jump through so many hoops to get into treatment,' said one participant, while another commented: 'I wanted to try being drug free, but felt very odd and soon relapsed. I asked to come back into treatment quickly so I wouldn't lose everything but they said it's not possible to do that because there are rules. I would have been dead when I overdosed if my friend hadn't been there.'

## CLIMATE OF MISTRUST

This lack of flexibility was cultivating a climate of mistrust. 'They asked me about my motivation and didn't like it when I said, "I'm here, isn't that enough",' said one person, while others had become used to feeling that services were not listening to them. 'If you have your own answers, don't ask me for mine,' was Linda's response to this; while Deb commented that her reaction had been, 'If you don't want to listen, tell me what you want to hear.'

In practical terms, services' unwillingness to be flexible could put an insurmountable hurdle in front of treatment: 'I missed the first day of my three-day pick-up because my child was ill and I had to go back for re-titration,' said one mother.

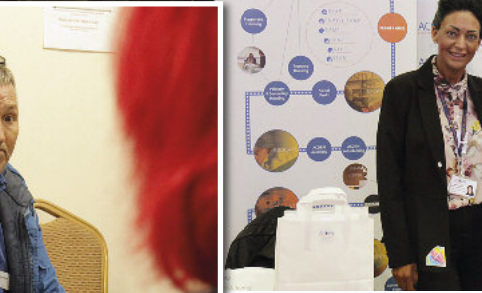
Some felt that they could not risk being honest about their needs or challenge treatment provision for fear of the consequences: 'I feel that I can never say what's going on with me or ask for something like an increased dose, because it means they will probably reduce me or put me back on daily dispensing, which is impossible as I need to live,' said Angela.

Alisha was confronted with stipulations when trying to access hepatitis C treatment: 'They told me I needed to reduce my dose before I could start hepatitis C treatment, but I knew they were wrong from going to a HCV support group,' she said. 'So I agreed to the reduction but bought some methadone to keep my dose the same. It's madness that I can't be honest.'

For many, the stigma of being identified as a 'drug user' permeated services and blocked the chances of a trusting and beneficial relationship with staff. Linda had







frequently experienced the attitude of 'there's a queue over there for people like you', while Billy's experience was that 'one worker said to me on first presentation – we know you people lie, so I will decide what you get'.

### 'TOP-DOWN' CULTURE

They also speculated that the 'top down' culture of many organisations was affecting staff's capacity to connect, particularly if they were not allowed to disclose to clients that they had themselves been in treatment.

'My friend disclosed about her history of treatment and was quickly shown the door,' said one participant. 'The service manager's reason for dismissal was that it was colluding with clients, which must not happen.'

Karl backed up this scenario from personal experience: 'I was doing really well as a drugs worker and was offered promotion to team leader by my

manager. I explained that I needed to share something to show I was honest and committed, so disclosed that I was on methadone. Suddenly I went from star worker to being before a disciplinary for using drugs.'

A trusting relationship with a drugs worker was seen as paramount to success in treatment, right from the entry stage. 'I really need help but I'm scared of what they might ask me to do before I get a script,' said Jake, while another participant demonstrated the importance of continuity: 'I have had six key workers in the last six months – how can that be effective care? It's a shame as well, because number three really listened, and it was then difficult to go back to the usual situation of not [being listened to].'

'I never feel heard,' said Dan, a theme echoed by many participants, including Linda, who described the all-too familiar experience of completing an assessment to enter a service: 'They ask you how much drugs you are using and when you give your answer you risk being told that you can absolutely not be using that amount of drugs... Whenever I came across a person like that, I just used to say that they should fill out the form for me and I will sign it as they obviously seem to think that they know better than me,' she said. 'I feel like walking out as I am being called a liar.'

If she gets through this process, there can be a further wait before being scripted, she explained, and then a 'carrot and stick' approach to treatment – 'but without the carrot on the end of the stick. For example, if you are late for your appointment you may not even be given your script and could be asked to come back another time.

But if your worker is making you wait for ages, that's just tough.

'Sometimes you come to pick up your script and they've changed the amount that you will be taking,' she added. 'They have not discussed this with you first, but instead inform you when you come to pick up your script and by then it's too late to do anything about it. Your script has been written up and it becomes a "take it or leave it" scenario.'

### UNDERSTANDING

For some who could benefit greatly from treatment and advice, the opportunity is negated by the fear that they would be misunderstood and coerced into treatment they did not want or were not ready for.

Tom had considered going into treatment to tackle his long-standing use of pharmaceutical opioids – primarily oral morphine capsules, supplemented with a mixture of codeine linctus and promethazine (known as a 'dirty sprite').

'I have described my use patterns to drug services and asked if I would qualify for substitute prescribing,' he said. 'The service workers have said yes in principle, but what put me off going through the process was that I would be unlikely to be prescribed what I'm getting hold of now.'

'The other primary issue for me is supervision... I'd have to use something every day [breaking his usual pattern of spending 'three days per week fairly euphoric and the other days clear headed'] and how long would I be subject to supervision for? I

**'It's madness that I can't be honest.'**

**'I never feel heard.'**

**'I had to jump through so many hoops.'**

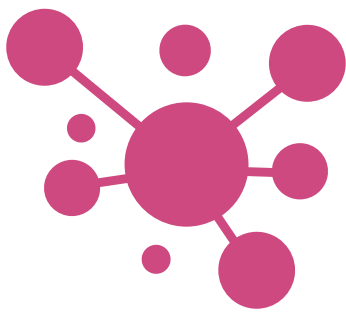
**'I have to fight at each appointment.'**

am hearing of people in different local authorities being stuck on daily supervised pick-up for years with no apparent end point... and that would be a problem – a deal-breaking one – for me.'

Clearly these are important issues that need talking about at the start of a trust-based relationship with a drug worker. The question that seemed to come from the session at conference was: how can we make sure that treatment moves beyond 'take it or leave it', to be tailored to the individual? **DDN**

**This article has been produced with support from Martindale Pharma, which has not influenced the content in any way.**



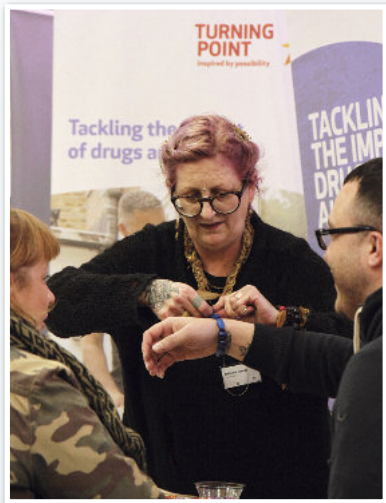


Get Connected  
DDN Conference 2018  
Thank you



# What an awesome day!

Billie Hands shares experience of her first DDN conference



I came up on the train from London with my fellow service users. This was great in itself as I got to catch up with peers that I sometimes don't see.

The talks that I went to were really informative, interesting and inspiring – as were the stalls! I was instructed on using naloxone as a life-saving treatment for heroin OD and now carry a take-home kit.

I heard about the amazing advances in hepatitis C treatment. I was one of the first at St Mary's Hospital hep C trials in 1999. It was a one-year treatment of injections in rotation – stomach, hip, stomach, hip – for one year. It was truly a nightmare and very harsh treatment, but I was

cured so all came good. Now it's eight weeks of tablets and a higher success rate.

I met B-3 together [Brent's service user council] and am hoping to visit them soon. Every service user's dream – a peer led, peer run organisation.

OMG, the food was just awesome, the dessert to die for, lashings of coffee and bickies!

Early in my recovery I found the joy of doing beading and jewellery making, so I set out my bag of beads on our Turning Point table. Armed with my stretchy elastic, I was ready! I had all sorts come and make them. Some were struggling; some had days, months or years of sobriety under their belts, and there were some who help us keep sober. One thing we all had in common was finding that making a stretchy beaded bracelet brings laughter, joy, serious talk, comradery, achievement and much, much more laughter.

Symone our service user lead, with her impeccable planning skills, got us there and back without out any delays on a very cold day.

I got home knackered, educated, informed, content, smiling and sober!

**Billie Hands, service user, Turning Point**



'It was really special to know that people thought a lot of my story.'

KELLY GEORGE

## Moving picture

**KELLY'S STORY**, the winning entry of last year's Recovery Street Film Festival, opened the afternoon session of DDN's conference. Standing on the platform to introduce her moving and powerful story of addiction, homelessness and losing her children, Kelly thanked those who had helped her to get her recovery on track and looked forward to continuing to build her future. Delegates showed their appreciation of her inspirational bravery.

If you would like to share your story through film, visit [www.recoverystreetfilmfestival.co.uk](http://www.recoverystreetfilmfestival.co.uk) for entry details and a useful guide to get you started.

### DDN WOULD LIKE TO SAY A BIG THANK YOU TO EVERYONE WHO SUPPORTED 'GET CONNECTED'

Our sponsors Martindale Pharma, PHE, Nal Von Minden, and the *I'm Worth...* campaign, all of our speakers, organisations who exhibited and supported delegates' attendance, Changes UK Recovery Academy, Paolo Sedazzari for filming the event, Lee Collingham, and all the volunteers from The Coventry Recovery Community and CGL – Simon Morgan, Chris Jennings, Adam Finnegan, George McCranor, Bess Curtis, Lauren Stewart, Jon Sellars, Steve Burford, Chris Thompson, John Seymour, Paddy Noonan, Marcus Hails, Ryan Small, Gary Nuznyi, Louise Morely, Mark Parrott, Dave Ayriss, Julia Maitland, Kath Podmore, Debbie Reed, Una Chedwiggen, Sian Hailes, Russell Johnson.

**Lastly and not least, to all our delegates who made it such a vibrant and amazing day!**



# LETTERS AND COMMENT

**DDN WELCOMES YOUR LETTERS** Please email the editor, [claire@cjwellings.com](mailto:claire@cjwellings.com), or post them to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Letters may be edited for space or clarity.



**'It seems self-evident that there is a useful piece of work to be done with those service users who smoke, while they are in treatment, to encourage them to make the switch to vaping as a part of moving toward a healthier lifestyle...'**

## THE POWER OF E-CIGS

I am writing in support of Dr Neil McKeganey and his view on the prescribing of e-cigarettes (*DDN*, February, page 18). As a proponent of harm minimisation in all its forms and bearing in mind the alarming percentage of service users in their forties and fifties with a diagnosis of COPD, anything that can reduce the numbers smoking tobacco is to be welcomed.

In 2008 at Build on Belief we did an impact evaluation and asked our service users how many of them smoked tobacco. The answer was 73 per cent – more than three times the national average. In 2014 we repeated the evaluation and asked the same question. The answer didn't change by a single percentage point and remained at 73 per cent. Then, in 2016 we did another, smaller survey in one borough and were astonished to discover the percentage of tobacco smokers had dropped to 50 per cent.

The following year, we thought to ask how many of them used e-cigarettes. The answer was 23 per cent, the exact percentage of the recorded drop in tobacco smokers. Interestingly, the great majority of those who had switched to vaping were in treatment and identified as being in recovery.

It seems self-evident that there is a useful piece of work to be done with those service users who smoke, while they are in treatment, to encourage them to make the switch to vaping as a part of moving toward a healthier lifestyle if they are unwilling or unable to give up tobacco. The health benefits would be enormous, and our research suggests that a significant number would, with a little support, do so.

*Tim Sampey, chief executive, Build on Belief*

## ROAD TO RECOVERY

**I sincerely found the experience of the DDN conference really amazing as a new peer mentor for Turning Point Leicester. I had no help from the armed forces and left after 30 years both as an engineering apprentice and soldier, followed by becoming an officer with the rank of captain.**

**I was simply told 'as an officer, sort yourself out!' I had a well-won nervous breakdown and PTSD that will be with me for life. I take professional counselling once a month and have been abstinent from alcohol for nearly four years now. I left the armed forces 20 years ago and never once as a family man thought a road to hell was ahead. I now enjoy life with my lovely wife of some 47 years – without her support I know I would not be here.**

*Trevor Mills, by email*

## GET THE PICTURE

Natalie Davies' outstanding analysis of the Cycle of Change (*DDN*, February, page 20) was let down by your illustration. Natalie's discussion demonstrates that the stages of change model is a really good description of what happens when people make a significant shift in habits and behaviour.

When it was first introduced in the early 1980s some in the UK fell on it a little too enthusiastically. Whole services were reconfigured to reflect the stages as though they were discreet, evidence-based stepping stones in a process. In truth, there was probably little harm done. A good description is better than what we had before. It certainly chimed with the emergence of broader, more nuanced understandings of alcohol and other drug use that were overtaking simplistic, diseased models.

The stages of change model has become a staple of addictions training presentations ever since. It is accessible. Many of us will have lost count of the number of times we've been presented with it, often by people who apparently haven't read any of the articles and books the originators produced.

How many of these trainers and presenters have noted that since 1992 the term 'relapse' no longer featured. The diagram describing the model changed from a circle to a spiral. In 1994 the new diagram featured in a book (for the benefit of those of us who don't have easy access to academic journals).

Your illustration includes the 'r' word. Most addictions trainers continue to use the older diagrams and spout on unthinkingly about Relapse (sic) despite the fact that it is over 25 years since the original authors eschewed the 'r' word in their model. Obviously there are reasons for this. These probably include:

- *It's a challenge to keep up to date*
- *People don't read journals, or books*
- *It is hard to draw a spiral*
- *We don't like change apparently (especially to our favourite model of change)*
- *The diseased models are alive and sick and worryingly continue to infect the field and the language we use to train new entrants and the wider community.*

New ideas take time to catch on. Prochaska & DiClemente's model was an exception. Their Cycle of Change is here to stay. It has been more than a quarter of a century since they (with Norcross) stopped talking about relapse. Anyone claiming to cite them to add legitimacy to their views on alcohol and other drugs should stop using the 'r' word right now.

As a field, we have a duty to advocate for the people who need our services. We do them no favours by education and communications that wilfully misrepresents

the work of key academics. We can't really expect journalists and politicians to get reporting and policy right if we're 25 years out of date (and counting) ourselves.

*References:*

*Prochaska, J.O., DiClemente C.C., Norcross J.C. (1992) In search of how people change. Applications to addictive behaviors. Am Psychol 47(9):1102-14*  
*Prochaska, J.O., Norcross, J.C. & DiClemente, C.C. (1994). Changing for Good. New York: Morrow.*

*Trevor McCarthy, independent consultant*

**Natalie Davies, assistant editor, Drug & Alcohol Findings responds:** We would like to thank Trevor McCarthy for his comments on our article about Prochaska and DiClemente's 'stages of change' model – especially for clarifying that the diagram featured is no longer an accurate depiction. There are many diagrams of the stages of change in circulation, but just looking at a sample of publications from the originators, it is apparent that they went on to embrace a way of describing the stages where a lapse or relapse did not necessarily mean that people regressed all the way back to where they started.

They recognised that people can learn from their mistakes or what didn't work, and try something different the next time. For example, this was illustrated in 1992 with a 'spiral' diagram (each loop in the spiral taking people closer to lasting recovery), and in 2003 with an adapted 'cycle' diagram placing the first stage (pre-contemplation) outside the circle to illustrate that people re-'cycling' through the stages would likely not return to where they started. We have made changes to the hot topic on the Effectiveness Bank website to reflect this, and would encourage readers to visit: [http://findings.org.uk/PHP/dl.php?file=cycle\\_change.hot](http://findings.org.uk/PHP/dl.php?file=cycle_change.hot)



# VITAL LINKS



The group of NHS providers, NHSSMPA, is looking at new ways to make sure service users stay connected with essential skilled healthcare

**N**ostalgia isn't what it is used to be' goes the quote, but are drug and alcohol services what they used to be? Well no. Historically, before the formation of the National Treatment Agency (NTA), some areas saw two year plus waiting lists for opiate substitution therapy (OST), and investment in alcohol services was severely lacking.

While there had since been improvements in these areas, the combination of commissioning by local authorities, the global financial crash and ongoing austerity has conspired to result in devastating disinvestment in our services.

Disinvestment and retendering cycles have resulted in changes in the skill mix of services, with fewer nurses, doctors and psychologists (those registered with professional bodies) in teams, and an over-reliance on staff without professional registration or specialist training, and volunteers. There has been a significant loss of knowledge, practice and skills along the way, as provider organisations design services that try to manage the reduction in budgets while still meeting need.

The need for high calibre clinical skills and expertise were recently highlighted by two eminent leaders in the field – professors Colin Drummond and Sir John Strang in the *Mental Health Times* and *BMJ* respectively. Professor Drummond stated:

*'Without proper care there are serious risks including epileptic fits and hallucinations, brain damage, suicide and risk of overdose. Yet many services do not have doctors or nurses with sufficient specialist training and competence to provide safe care.'*

This highlights that registered staff and doctors have been in steady decline, but also that many of those recruited lack the relevant training, supervision and support to ensure high quality provision for complex service users. These experts do exist, but more and more they are in a lead role rather than 'on the ground', which can affect their contribution locally. There are only so many hours in a week.

A reduction in budgets means cash-strapped services are able only to work the purest interpretation of the service specification, compounding the effect of smaller budgets with a loss of social capital from providers.

As a sector we have been eager to seek solutions, usually through collaborative partnerships across health and social care. The significant decline in registered staff, including nurses, social workers, clinical psychologists and doctors means it is harder to achieve improvements even when the willingness has been there. Being able to speak the language of those that you wish to collaborate with has its advantages and enables effective partnership to prosper far more easily. The loss of these posts (and the assurance of the NHS badge) has negatively affected partnerships, most notably with health colleagues.

The continued reduction in professionally registered staff in treatment services is diluting the skills and professionalism required to address the needs of our service users. A recent CQC publication reports on serious concerns uncovered in many of the independent detoxification clinics across the country. Furthermore, the reduction in registered staff and the number of NHS providers jeopardises the overall standard of care and the ability to forge meaningful ventures to enhance care pathways. In short, the loss of these providers, practice and skills means some drug and alcohol services are relying on limited clinical expertise, to the detriment of care.

Public Health England (PHE) recently commissioned three publications highlighting the importance of the roles of nurses, addiction specialist doctors and psychologists within the drug and alcohol sector (available at [www.gov.uk](http://www.gov.uk)). They are a call to commissioners and providers that these skills and professional contributions are core and essential, and that their loss is having an impact on the overall provision of care as well as putting service users at risk.

As a group of NHS providers, NHSSMPA hopes to contribute to changing this. The following examples show innovations by NHS services where good practice has been implemented to improve the wellbeing of our service users. They also illustrate





## STREET SEX WORKER INITIATIVE

A low threshold initiative was developed for street sex workers who elected to engage with it, and who were provided with 30mg oral methadone. They could pick up on any or all days, seven days a week, giving them the option of working and a safety net. Two pharmacies were part of the team and would work in partnership, closely monitoring risk. The expectation of the sex worker was that they would attend a three-monthly clinic. Its format was devised by service users and access was available for:

- *rape crisis intervention*
- *genito-urinary medicine services for smear tests and sexually shared infections, high vaginal swabs and any necessary treatments*
- *family planning for depot contraception injections*
- *midwives for pregnant service users*
- *needle and syringe exchange*
- *condom provision*
- *vaccination for hepatitis A and B*

Direct referral to colposcopy and appointments was provided at the time of attendance, as well as the ability to dress wounds, listen to breathing to identify respiratory disorders, examine injecting sites, monitor drug use and move into mainstream treatment if that was what the person wanted. Apart from the obvious direct benefits for service users it also improved relationships between services and the sex workers' access to these.

why retaining an appropriately balanced and skilled workforce is essential.

### ENGAGING COMPLEX CLIENTS

Nursing staff learned compression bandaging to work with some difficult-to-engage service users with venous leg ulcers. We worked with people who were not turning up to the dressings clinic, not having doppler studies, continually having breakdown of their ulcers, and suffering widespread infection, cellulitis and venous eczema.

We engaged with their GP practice and developed a shared care type approach. We increased outreach to service users and managed their dressings as per the care plan. We would make sure they attended doppler appointments where the GP and nursing staff would manage the dressings. This allowed a relationship to develop between the service user and the nursing team and allowed us to pull back when the service user was fully engaged.

### DERBY'S HIT

Derby Healthcare Foundation NHS Trust looked at their care delivery in an effort to address the effect of diminishing resources. They devised a 'red flag system' to identify service users most at risk of accidental overdose, through reviewing six years of local mortality data.

The common themes that correlated this risk of accidental overdose were largely expected – continued intravenous use of illicit drugs, erratic engagement, poor physical and/or mental health. But less considered was hepatitis C status and the link with those living in isolation. Other risk factors were a hospital admission in the last 12 months and having a physical health condition such as chronic obstructive pulmonary disease or a deep vein thrombosis. Being prescribed additional medication with a sedating effect by their GP was also a marker.

Collecting and analysing this data identifying who was at risk led to the creation of a health improvement team (HIT) in Derbyshire. This approach was

incorporated into a tender for Derbyshire treatment services at the beginning of 2017, and the new service went live in April 2017. The HIT do not carry a caseload, but instead support key workers with their higher risk service users, and the sole focus is on improving their physical and mental health and preventing drug-related deaths.

Those with chronic and deteriorating physical health will have greater priority placed on managing these conditions integrated with their substance misuse treatment. Physical health assessments and advice will be provided by the HIT nurses, including more routine care such as blood-borne virus testing and vaccinations alongside ECG.

The role of nurses was central to the success of the Derby approach, and is fundamental to the other examples provided. Over the past decade or so, nursing and other clinical expertise has been lost – meaning that within drug and alcohol treatment, as many of our service users age and require broader health and social care, clinical expertise is less accessible. The multi-disciplinary team, which includes those with clinical expertise working with other disciplines and those with lived experience, has never been more important.

NHSSMPA is also part of a national working group led by the Royal College of Psychiatrists and PHE, with third sector colleagues, that is trying to reverse the reduction in addiction psychiatrists – an example of the sector responding to an important workforce issue. It is at our peril that we do not ensure that drug and alcohol services incorporate the correct blend of skills and disciplines, including highly skilled clinicians.

**Authors are Jon Shorrock, Avon and Wiltshire Mental Health Partnership NHS Trust; Linda Johnstone, Cheshire and Wirral Partnership NHS Foundation Trust; Martin Smith, Derbyshire Healthcare NHS Foundation Trust; Mike Flanagan, Surrey and Borders Partnership NHS Foundation Trust. All are members of the NHS Substance Misuse Provider Alliance (NHSSMPA).**



'Disinvestment and retendering cycles have resulted in... a significant loss of knowledge, practice and skills, as provider organisations design services that try to manage the reduction in budgets while still meeting need.'



# BRIEF ENCOUNTER



Alcohol brief interventions promised a way of improving the nation's public health – so what happened to this ambitious initiative? **Mike Ashton** looks back at a 27-year journey

The advent of brief interventions represented a radical realignment away from aiming for abstinence among relatively few 'alcoholics' to reducing risk among risky drinkers of all levels. Instead of narrow and intensive, the strategy was to spread thin and wide, deploying easily learnt interventions that could be delivered in a few minutes by non-specialist staff.

Drinkers whose consumption generated no impetus to seek advice were nevertheless to be offered it, after being identified by screening questions or clinical signs while coming into contact with services for other reasons. Some might not benefit and others only modestly, but – unlike treatment – the *population* was the target. Screening and brief intervention was primarily a public health strategy to reduce alcohol-related harm at the level of a whole population, to a degree otherwise unattainable without imposing politically unpalatable restrictions on the availability of alcohol.

This is the story of the partial retreat from those ambitions, traced through three British studies in which the same researcher was involved – Professor Nick Heather, the first to evaluate an alcohol brief intervention in primary care, a venue chosen for its near-universal reach. The most influential thinker and

researcher on brief interventions in Britain, his work forms the spine of the research-driven realisation that hopes and potential were one thing, realising them another.

Conducted in Dundee in 1985, the results of his first trial can in retrospect be seen as a harbinger of what was to come. Whether screening had been followed by no advice on drinking at all, a very brief warning from the doctor, or the more elaborate 'DRAMS' brief intervention, drinking reductions did not significantly differ. The researchers commented: 'The results... provide little support for the hypothesis that the DRAMS scheme is superior to simple advice and to no intervention.'

Fifteen years later recruitment started for another study co-authored by Professor Heather, seen as the UK trial closest to routine practice, an essential step in showing 'potential' could be turned into public health gains. After suffering from low recruitment to the trial and low rates of screening and intervention, it found no statistically significant evidence that a five- to ten-minute brief intervention by primary care nurses in England was more effective than usual unstructured advice, despite costing nearly £29 more per patient.

Though appreciating the difficulties, in 2006, the year these results were





published, Professor Heather still optimistically identified the 'steadily gathering momentum' of an 'international movement dedicated to reducing alcohol-related harm by achieving the widespread, routine and enduring implementation of screening and brief intervention'.

That same year, the UK Department of Health had funded a more definitive study, a real-world test with a sample large enough to detect small effects, overcoming a limitation of the previous two trials. Professor Heather was one of the investigators. For alcohol screening and brief intervention in Britain, the 'SIPS' study was critical, intended to help government decide whether to invest in incentivising these activities in GPs' surgeries – there were also parallel studies in probation and emergency departments.

In March 2012, a conference and factsheets revealed the unexpected results, later confirmed in formal publications: brief interventions as normally understood were generally not found to be any more effective than an unsophisticated 30-second warning (see panel opposite) to patients about their drinking plus an alcohol advice leaflet.

This terse warning was to be a relatively inactive 'control' condition against which the brief interventions could shine. Instead, it captured the limelight. 'Do just the minimum,' is the message austerity-hit commissioners might have received, encouraged by the 'less is more' take on the findings from the Department of Health's director of health and wellbeing. In fact, whether any of the advice options were better than doing nothing could not be determined by the trial.

Another important finding was that implementation often required specialist support and patient throughput was low. Though incentivised with per-patient payments, the average primary care practice identified just two risky drinkers a month.

**T**he year these results were revealed, 27 years after embarking on the first trial in Dundee, Professor Heather addressed the key question posed by the title of his article: 'Can screening and brief intervention lead to population-level reductions in alcohol-related harm?' The optimism expressed just six years before had evaporated, though not entirely dried up: 'Widespread dissemination of [screening and brief intervention] without the implementation of alcohol control measures... would be unlikely on its own to result in public health benefits.'

Screening and brief intervention might persuade individuals to cut their drinking, but as a public health tool, it had become relegated to a (still potentially important) adjunct to the primary elements – the availability restrictions to which brief interventions had been seen as a more acceptable alternative.

Of the four requirements for public health benefits, Professor Heather judged only one had been satisfied – evidence that brief intervention 'reduces consumption to low-risk levels in some of those who receive it' – and depending on how many the 'some' are, even that has arguably not been demonstrated in

'Instead of narrow and intensive, the strategy was to spread thin and wide, deploying easily learnt interventions that could be delivered in a few minutes by non-specialist staff.'

**Thank you for taking part in this project. Your screening test result shows that you're drinking alcohol above safe levels, which may be harmful to you. This leaflet describes the recommended levels for sensible drinking and the consequences for excessive drinking. Take time to read the leaflet. There are contact details on the back should you need further help or advice.**

real-world circumstances. Meeting the remaining three requirements was, he wrote, 'currently unlikely, either because they are difficult to achieve or because there is no evidence to support them'.

A major gap was that 'public health potential... is unlikely to be realised without the widespread deployment of universal screening', something no national health care system had been able to achieve. The ideal scenario of drinking being asked about at every contact with a health professional, followed if indicated by help or advice, 'might not be tolerated by the general public, not to mention the health professionals asked to deliver it, and might therefore be an electoral liability to any political party supporting it'.

By 2017 his caution was being cited and reinforced by UK and US brief intervention researchers. Their downbeat verdict was that 'After more than three decades of study in primary care, it now seems unlikely that brief interventions alone confer any population level benefit, and their ultimate public health impact will derive from working in concert with other effective alcohol policy measures.' What prompted this conclusion was lack of evidence that in real-world circumstances, brief interventions reduce alcohol-related ill-health, coupled with the difficulty of persuading GPs to focus on not-very-heavy drinking when patients often have multiple lifestyle risk factors – and when they and their doctors may be more concerned with here-and-now problems rather than the risk drinking will cause future harm.

It is in the nature of the methodologies used to evaluate screening and brief intervention programmes that the door cannot be closed on the possibility that they can appreciably improve public health – if, for example, interventions are refined and incentives to implement them and checks on quality strengthened. And although wider public health benefits are doubtful, these procedures can benefit individual heavy drinkers.

Nevertheless, the rather intractable worlds of doctors and patients trying to cram their priorities into a ten-minute consultation in which alcohol has no natural place has helped drain the optimism of past decades. Even in relatively ideal circumstances, screening and brief interventions are not likely to affect the numbers needed to substantially relieve the UK of its burden of alcohol-related harm.

**Mike Ashton is editor of Drug and Alcohol Findings, <http://findings.org.uk>**

**The author is grateful for comments from Professor Heather. For the full story and more on brief alcohol interventions see [http://findings.org.uk/PHP/dl.php?f=hot\\_alc\\_BI.hot&s=dd](http://findings.org.uk/PHP/dl.php?f=hot_alc_BI.hot&s=dd)**



# COMPLIANCE

# HAVE YOUR SAY!



Don't miss the chance to change CQC inspections, says **David Finney**

**The Care Quality Commission (CQC) has recently issued a consultation on changes to the inspection of independent healthcare services, and this includes substance misuse services. The consultation has a deadline of 23 March 2018 for responses and is available via the front page of the CQC website. In my view it is urgent that substance misuse services participate in this consultation, otherwise a key window of opportunity will be lost to influence the practice of the regulator.**

The consultation document and previously issued *Key lines of enquiry for healthcare services* (July 2017) contain very little mention of substance misuse services at all, suggesting that they are being overlooked within regulation.

While CQC still publishes some 'brief guides', these mostly relate to detoxification services rather than other residential or community services. In practice there are regional leads for substance misuse services, but below that level the experience of

inspectors is variable, so there is a danger of inconsistency in inspections. Specialist professional advisors have been used alongside inspectors, but the overwhelming majority have been nurses or doctors with experience of NHS settings rather than independent residential or community services. Once again, it seems that residential rehabs, in particular, are being marginalised within regulation.

The new approach has positive and negative aspects for the substance misuse sector – however, a key problem at present is lack of engagement with the sector by CQC corporately. A report highlighting the failings of detoxification services has been published (30 November 2017), but no other recognition of the residential rehabilitation services has been forthcoming. When substance misuse services were regulated within the adult social care directorate of CQC, many providers felt that they were not understood by the regulator.

To avoid substance misuse services becoming marginalised within regulation once again, providers need to make an active response to this consultation. The sector should come together and lobby CQC to help it to become the informed and proportionate regulator it aims to be.

**David Finney is an independent social care consultant who has worked with government inspection bodies**

## Key features of the consultation

CQC say that the aim of their new approach is to be 'targeted, responsive and collaborative'. They propose that some key developments will be:

**a. Unannounced or short-notice inspections:** an initiative to be launched in April 2018. This will be a change from the current practice of giving long notice for announced inspections and mean that providers will not have the opportunity to organise the day so that they can present their service to the inspection team. Neither will they will be able to arrange for service users to be available to speak to the inspector, apart from by taking them out of their existing programme commitments at short notice.

**b. A new model for collecting data, called CQC Insight.** This seems to match the type of data collection used by the NHS, but may prove difficult for smaller residential services that do not have the data systems available to larger corporate bodies.

**c. Rating of services.** The characteristics for rating services defined in the assessment framework (KLOE) are very general, and do not reflect what a 'good' or 'outstanding' substance misuse service looks like. There is the possibility that services may be rated according to the subjective view of the inspector, rather than a recognised benchmark.

**d. Changed frequency of inspections:** so that outstanding services are inspected every five years, good services every three and a half years, services requiring improvement every two years and inadequate services every year. There is also a provision for 'special measures', which will lead to more intensive monitoring. I have two major concerns for services awarded a lower rating: if there is a long time before another inspection, this may adversely affect the availability of the service to local authority funded placements and the business overall; and secondly, it is likely that services will not be able to admit new service users, which will very quickly undermine the business financially and not allow it to recover.

**e. Effective use of accreditation schemes.** In contrast, this is an opportunity for the sector,

because CQC say that these schemes could shorten inspections or even replace them altogether. Although previous accreditation schemes for this sector have fallen by the wayside, this is a new chance to focus on the distinctiveness of substance misuse services.

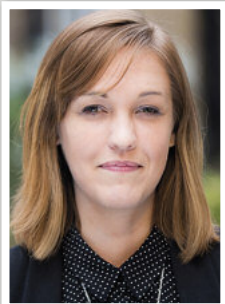
**f. Relationship management.** This is about the development of strategic planning and the encouragement of improvement within the sector. Some larger providers already have a relationship manager within CQC, but this function has been inconsistent across the country. So the challenge is to regularise the arrangement so that all providers have the advantage of access to this service.

**g. Emphasis on well-led domains.** Good leadership and governance is clearly important; however, aspects which tend to feature highly in the consultation are document-based factors such as quality assurance systems and methods for implementing lessons learned. These are relevant, particularly in corporate bodies, but it is equally important to recognise the impact of management, which is in regular informal contact with service users and their progress through recovery.





## LEGAL LINE



**Nicole Ridgwell answers  
your legal questions**

### **OUR INSPECTOR HAD INSUFFICIENT EXPERTISE – CAN WE CHALLENGE?**

**Following a recent inspection we were unhappy with our CQC report. We felt that the person conducting the inspection did not have adequate experience of the substance misuse treatment sector and that the specialised nature of our service was not taken into account. Can we challenge our inspection on these grounds or ask for a second opinion from someone with more understanding of residential drug and alcohol services?**

This is a scenario we at Ridouts recognise all too well from our regular interactions with substance misuse providers. It is not unique to the sector but is certainly a greater problem here than in some others.

This is because, due in part to the relative youth of the sector in terms of distinct CQC regulation, inspection teams often include no specialist advisors (SAs) with expertise in the field; instead, teams may include SAs with NHS-only experience, contrary to CQC's published guidance emphasising the important role of SAs in inspections.

CQC's SA recruitment advert stated that the 'job purpose' of an SA was 'to provide specialist advice and input into the CQC's regulatory inspection and investigation activity. This advice ensures that CQC's judgements are informed by up to date and credible clinical and professional knowledge and experience'.

CQC consistently insists that inspection teams attend inspections equipped with individuals skilled and experienced in that specific environment. In the case of substance misuse sector providers, therefore, the appropriate SAs would without exception have substance misuse expertise relevant to that provider. As readers know, the NHS environment is wholly distinct from the independent sector and should rarely be compared. In the absence of appropriate SAs, inspection teams necessarily lack the judgement required for the job; inevitably, mistakes, misinterpretations and simply factual inaccuracies will occur.

Providers should not be afraid to challenge either the conduct or experience-level of the inspection team where this has clearly had an unfair impact on the draft report or seems otherwise inappropriate. This is best done through the factual accuracy process. Providers should also consider making a formal complaint on conclusion of the inspection, rather than on receipt of the draft report. This stops CQC from alleging that complaints are only raised when providers are unhappy with inspection results.

As said before in this column, challenging factually inaccurate reports and submitting detailed, evidenced complaints are necessary steps all providers must take to safeguard their reputations. All reports should reflect the reality of the service, rather than the prejudice and/or inexperience of the inspection team. Providers must remember that prospective service users and their families will use the finalised report, as will commissioners, to inform decisions about admission.

I also echo David Finney's article (see opposite) and encourage all providers to actively engage with the new CQC consultation. Providers can help CQC to appreciate the importance of expertise, and indeed the financial, resource and time costs of the legal appeals required to remedy the absence of such expertise. Providers can be the change they want to see, but if they stay silent they will only perpetuate the status quo.

*Nicole Ridgwell is solicitor at Ridouts Solicitors, [www.ridout-law.com](http://www.ridout-law.com)*

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