DRINK AND DRUGS NEWS

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DDN

RECOVERY FUTURES

INCLUSIVE CITIES – A FORWARD-THINKING APPROACH

INSIDE: Why are so many services failing women?

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ON THE COVER
Recovery in the community, p6

'Recovery is not just an issue of personal motivation, but is also about acceptance.' Our cover story (page 6) examines the thought that recovery doesn't happen in a vacuum but can thrive with community support. How often do we focus solely on the individual – their medication, their state of mind, their 'readiness' to take the step to sobriety? The inclusive cities model looks at the great potential of harnessing the power of communities. It also examines the difficulties of negative community influence – the barriers created by exclusion and stigma.

The divide between those inside and outside recovery becomes even more stark when we look at our success rate with treatment for women. Drug-related death rates among women are the highest since records began, and what are we doing about it? Do we know why women aren't accessing treatment? Do we understand the barriers that are preventing many women from seeking help? Do we take account of the fear that drives women to try to hide their personal crisis from anyone in 'authority'?

Read our article on page 8 and consider whether service provision in your area is reaching out to women's needs – and let us know if you have ideas to share. As the parliamentary group speakers stated very clearly, we need to do a lot more – starting with demanding more from each other as treatment providers.

In the wrapper with this month's issue, you'll find Routes to Recovery, our latest residential rehab guide. We hope you'll find it useful when looking for the absolutely right option for your clients.

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

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AGGRESSIVE MARKETING AND CHANGING ATTITUDES DRIVING INCREASED CRACK USE

AGGRESSIVE MARKETING BY DEALERS and a change in attitudes towards the drug were among the reasons for increasing levels of crack cocaine use in England, according to an investigative report from Public Health England (PHE) and the Home Office.

Crack has become increasingly available and affordable in recent years, following a surge in cocaine production since 2013. Dealers were also selling the drug in smaller quantities, says the document, as well as offering free samples with their heroin or 'three-for-two'-type deals, something particularly common with dealers aiming to infiltrate new markets and build a customer base.

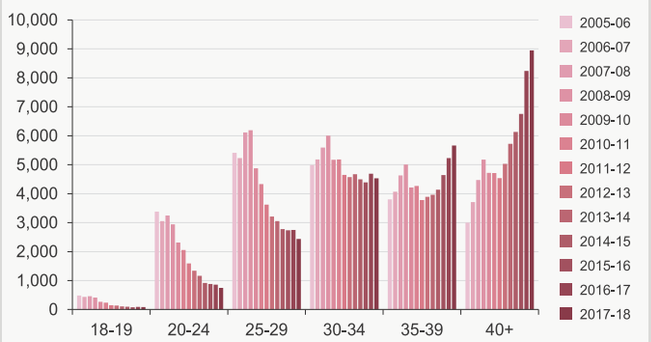
Attitudes to crack were also changing, however. Many service users, treatment professionals and police officers interviewed for the report thought that 'the stigma of using crack had declined in recent years'. Last year Kevin Flemen warned in a *DDN* cover story that 'the stigma-driven barriers between powder cocaine and crack may be breaking down' (*DDN*, June 2018, page 6).

The report, which focuses on six areas in England, found that while the majority of people using crack were 'observed to be existing heroin users', some dealers were also 'opening up new markets' of younger, first-time users who were not using heroin or engaged with treatment services. There was 'clear evidence' of county lines activity, although this varied from area to area, with these groups much more likely to engage in serious violence and 'exploit vulnerable young people and drug users'. A 'reduced focus' on drug dealing by the police – and fewer police on the streets – were also thought to be contributory factors, with less capacity to target dealers or people carrying drugs.

The document is published at the same time as a report from Liverpool John Moores University which found that the estimated number of people in England using opiates and/or crack had risen by 4.4 per cent between 2014-15 and 2016-17, an increase that was 'statistically significant'. Most crack users in treatment, however, were there 'because they're using heroin as well, and it's the heroin problem that brought them in', says PHE, which meant that local treatment systems had to respond to increasing levels of unmet need.

Number and age of new treatment presentations for opiates and crack cocaine

Source: PHE, https://assets.publishing.service.gov.uk



'This report will come as no surprise to those working on the frontline, who will have seen first-hand this surge in crack use in their communities,' said PHE's director for drugs, alcohol, tobacco and justice, Rosanna O'Connor. 'Local areas, more than ever, need to continue to invest in effective drug services if we are to stop the creep of this highly addictive drug into the wider community and people's lives being torn apart. Services need to reach out to crack users and offer more attractive and tailored support to meet their specific needs.'

Increase in crack cocaine use enquiry: summary of findings at www.gov.uk

Estimates of the prevalence of opiate use and/or crack cocaine use, 2016/17: sweep 13 report at www.ljmu.ac.uk

COUNTY CRIMES

THE NUMBER OF POTENTIAL VICTIMS OF TRAFFICKING AND MODERN SLAVERY reported to the authorities has increased by more than 80 per cent in two years, according to the National Crime Agency (NCA). Just under 7,000 potential victims were referred in 2018, with the numbers of British citizens and minors reported nearly doubling since the previous year. Both increases were partly driven by county lines activity, something that was 'of particular concern', said NCA deputy director Roy McComb. 'These are often vulnerable individuals – often children – who are exploited by criminal gangs for the purposes of drug trafficking.' It was also likely that the figures only represented a 'snapshot' of the true scale of the problem, he added.

Figures only represent a 'snapshot' of the true scale of the problem.

ROY MCCOMB

END OF THE ROAD

CRANSTOUN HAS ANNOUNCED THAT LONDON-BASED DETOX UNIT CITY ROADS IS TO CLOSE next month, after 40 years of operation. The decision has been reached after a lengthy review, says the charity, with the service 'no longer considered sustainable'. The closure comes at a time when there 'remains a high level of need for this type of provision' it states. 'Despite this, diminishing resources have consistently reduced referrals below the level required to support the ongoing operation. In making this announcement, we wish to acknowledge the dedication and commitment of our current and previous staff groups and volunteers, who have worked tirelessly for the betterment of people's lives. Additionally, we wish to recognise the efforts and courage of all people who have used the service as a platform for stabilisation, and recovery.'

COMMUNITY CALL

GLOBAL GOVERNMENTS SHOULD BE CONSIDERING HARM REDUCTION, decriminalisation and legal regulation, according to the Police statement of support for drug policy Reform, which was launched at the UN in Vienna last month. If police forces concentrated on reducing risks and providing more humane responses it would lead to 'better outcomes for the whole community', it states. 'It is the police who see the real outcomes of drug policy,' said Durham PCC Ron Hogg. 'This international statement is the first time police voices have come together to answer back. We are here as members of the policing community to say to governments that current policies don't work.'

UP IN SMOKE

CUTS TO PUBLIC HEALTH BUDGETS mean that 44 per cent of local authorities no longer have specialist no smoking services open to everyone in their area, according to a report from ASH and Cancer Research UK. Funding has fallen by more than £40m since 2014-15, says *A changing landscape: stop smoking services and tobacco control in England*. 'Local authorities are having to make the best of a butchered public health budget and many are managing to do just that,' said ASH director of policy, Hazel Cheeseman. 'But councils need to avoid a race to the bottom and ensure they maintain investment in stop smoking support and the other activities that will reduce smoking and tackle inequalities – this necessarily requires sustainable funding from central government.'

Report at ash.org.uk

LACK OF HARM REDUCTION SERVICES IMPEDING HIV PROGRESS, WARNS UNAIDS

AROUND 99 PER CENT OF PEOPLE WHO INJECT DRUGS LIVE IN COUNTRIES THAT ARE FAILING TO PROVIDE ADEQUATE HARM REDUCTION SERVICES, says a report from UNAIDS. Despite overall new HIV infections declining globally, infection rates among people who use drugs remain unchanged, says *Health, rights and drugs: harm reduction, decriminalisation and zero discrimination for people who use drugs*.

Although ensuring comprehensive harm reduction service coverage such as NSP programmes, substitute prescribing and HIV testing would 'kick start progress' on stopping new infections, few UN member states were living up to the 2016 agreement that came out of the UN General Assembly Special Session (UNGASS) on the World Drug Problem to establish an effective public health response (*DDN*, May 2016, page 4). Investment in harm reduction measures is falling 'far short' of what is needed for an effective HIV response, says the document – in a third of low and middle-income countries, more than 70 per cent of spending on HIV services for people who use drugs came from external donors.

More than half of the 10.6m people who inject drugs were living with hepatitis C, and one in eight were living with HIV, says the report. UNAIDS is calling for the full implementation of comprehensive harm reduction services, as well as ensuring that people who use drugs have access to prevention, testing and HIV and hepatitis medication.

Criminalisation and 'severe punishments' remain commonplace despite the evidence showing that decriminalisation of personal use and possession can increase the uptake of health and treatment services, says UNAIDS. Around one in five prisoners worldwide is incarcerated for drug-related offences, of which around 80 per cent are for personal use only.

'UNAIDS is greatly concerned about the lack of progress for people who inject drugs,' said executive director Michel Sidibé. 'By putting people at the centre and ensuring that they have access to health and social services with dignity and without discrimination or criminalisation, lives can be saved and new HIV infections drastically reduced.'

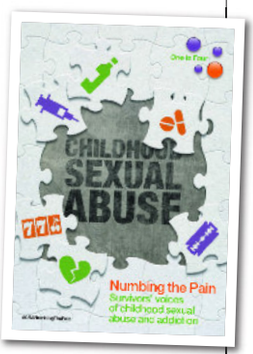
> 'Put people first and seek to safeguard their health, wellbeing and future.'
> YURY FEDOTOV

Meanwhile, a ministerial declaration emphasising a 'health and rights-based' approach to global drug challenges was adopted at the 62nd session of the UN Commission on Narcotic Drugs in Vienna last month. Responses that 'put people first and seek to safeguard their health, wellbeing and future' were vital, said UNODC executive director Yury Fedotov. A separate report, *What we have learned over the last ten years*, from the UN's Chief Executives Board, described punitive policies as 'ineffective' in reducing drug use and trafficking.

Reports at www.unaids.org and www.unodc.org

SURVIVORS' STORIES

DRUG AND ALCOHOL SERVICES need to 'make the link' between childhood sexual abuse as an underlying trauma for many people with substance misuse issues, says a report from the One in Four charity. The trauma of childhood abuse remains a 'poorly understand area', it states, affecting people's emotions and ability to relate to others. Services should be anonymously recording and collating disclosures of abuse as well as considering how they are 'supporting and signposting survivors to appropriate support', it says. They also need to make sure that all staff are trained to respond to disclosure and have an agreed process to support survivors. *Numbing the pain: survivors' voices of childhood sexual abuse and addiction at www.oneinfour.org.uk*



See feature, page 10

POTENT CONCLUSIONS

DAILY CANNABIS USE WAS ASSOCIATED WITH 'INCREASED ODDS' OF PSYCHOTIC DISORDER, according to a study across 11 cities published in *The Lancet Psychiatry*. Although 'disentangling causality where complex and confounded behaviours might be impacting on even more complex mental health outcomes is notoriously challenging', the study concluded that differences in frequency of daily cannabis use and use of high-potency cannabis contributed to a 'striking variation in the incidence of psychotic disorder', something that – given the increasing availability of high-potency cannabis – had 'important implications for public health'. *Cannabis and psychosis: triangulating the evidence at www.thelancet.com*

CRISIS TALKS

THE SCOTTISH GOVERNMENT IS CONVENING AN EXPERT GROUP to look at ways to address the country's rising rates of drug-related deaths. 'The status quo is simply not an option,' wrote public health minister Joe FitzPatrick in an article for the *Daily Record*, adding that 'even if a proposed course of action is controversial, we must act if it can be shown to reduce harm and save lives'. While the Scottish Government supports the introduction of consumption rooms and heroin-assisted treatment, legislative power remains in Westminster. 'If the UK government continues to refuse to act, we call on them to pass powers to the Scottish Parliament so we can do what is necessary,' he wrote.

> 'We must act if it can be shown to reduce harm and save lives.' JOE FITZPATRICK

WASTED CITIES

COCAINE RESIDUES IN CITY WASTEWATER were highest in Belgium, the Netherlands, Spain and the UK – particularly Bristol – according to EMCDDA's latest analysis. The project studied wastewater in 73 cities across Europe, and found increased traces of cocaine, amphetamine and MDMA in most cities. Methamphetamine, meanwhile, which had traditionally been concentrated in parts of Eastern Europe, was now present in Spain, Finland, Norway, Germany and Cyprus. *Wastewater analysis and drugs: a European multi-city study at www.emcdda.europa.eu*

The inclusive cities model is a forward thinking-approach to boosting people's recovery in the communities where they live, say **Professor David Best**, **Professor Charlotte Colman** and **Stuart Green**

Include me in

How does recovery happen? Research shows that people overcome addictions and recover through a combination of three factors. The first is personal factors such as maturation and personal motivation, the second is social factors like support from family and friends, and the third is community factors such as effective reintegration. This shows that recovery is not just an issue of personal motivation, but is also about acceptance – by family, friends and a range of organisations and professionals across the community.

In the beginning, research and practice mainly focused on understanding personal and social factors in recovery. But today we know that what is equally, or even more, important is one's relationship with the community – recovery doesn't happen in a vacuum. Therefore to support pathways to recovery, structural and contextual efforts are needed to supplement individually oriented interventions and programmes.

(Re)building one's relationship with the community is, however, a difficult journey. While the community could be central to recovery by building and strengthening bridges between members, it could also act as a barrier. People who struggle with addiction – even those in recovery – experience exclusion, stigma and discrimination, such as employers not offering them a job, landlords who discriminate against them, or neighbours who ignore them. Such a community has negative consequences for sustaining the recovery of its citizens.

It's against this backdrop of exclusion, stigma and discrimination at a community level that the drive for 'inclusive cities' arises. An inclusive city promotes participation, inclusion, and full and equal citizenship to all its citizens, including those in recovery. The first purpose is to build and promote inclusive cities for people who are in recovery from illicit drug and alcohol use, while the larger aim is to challenge exclusion and stigma through a championed model of reintegration for other excluded and vulnerable populations. This can be done by channelling peer successes, and building on innovation and existing connections.

The central idea of an inclusive city is that no one should walk the recovery path alone. In an inclusive city, the city council, private and public organisations, housing providers, welfare and health centres, employers, and neighbours commit to working together with people in recovery to support them in their recovery process. By focusing on social connection, an inclusive city aims to challenge exclusion, and by doing so reduce stigmatisation.

A strong example of social cohesion is the Northern Recovery College, where collective learnt, lived and worked experience based on 'everyone has something to give' comes together to share experiences of individual strength-based or community assets. There are countless examples of initiatives that fit within the idea of inclusive cities – they could be small steps involving limited budgets, or more structural steps such as establishing a social enterprise model.

One of the aims of an inclusive city is to celebrate recovery and to create a safe environment supportive to recovery. After all, celebrations involve rituals, fostering social bonding and strengthening solidarity and social cohesion by bringing people together. But although we celebrate a lot of events in our lives, we don't tend to celebrate successful recovery journeys.

One of the first steps to celebrate recovery, therefore, is to make recovery visible. Activities such as recovery marches, recovery games, recovery bike rides and recovery cafes have been an attempt to create a visibility around recovery, as well as to create a common bond and to challenge exclusion and stigmatisation. Equally important are visible and strong representations in local and mainstream media, to create a balanced view of recovery and wellbeing and demonstrate visible community benefits.

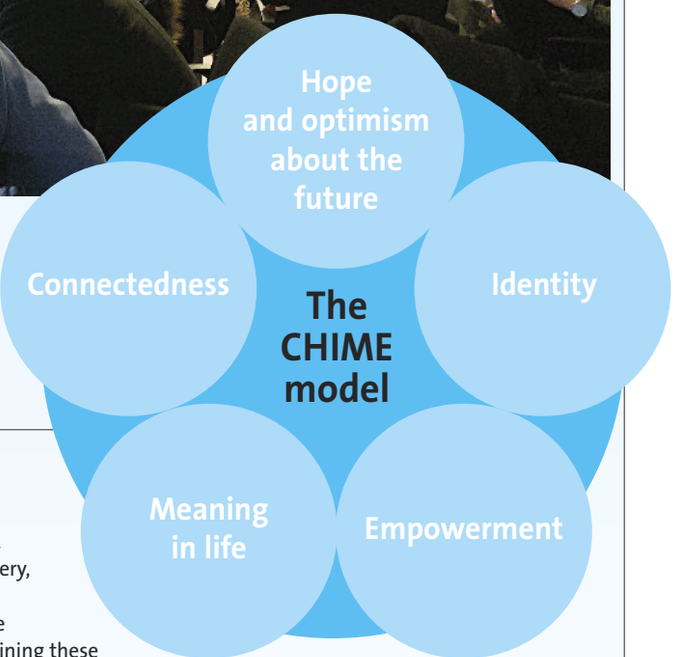
One example is high-profile clean-ups of injecting drug use litter near pharmacies, showing the value people in recovery place on where they live and helping to change public perceptions. We will attempt to collect success stories and promote innovations and exciting new initiatives through our website at http://inclusivecities.info

Another aim is to focus on peer and community support and cohesion. Setting up a recovery café – such as the Serenity Café in Edinburgh, or Nottingham's Café

More recovery models at:
www.drinkanddrugsnews.com

Above: (left to right): Stuart Green, service manager, Aspire Drug and Alcohol Service; Professor David Best, Sheffield Hallam University; Linda Nilsson, City of Gothenburg development manager; and Mulka Nisic, Recovered Users Network (RUN).

Above right: Beginning the process of recruiting community connectors at the Recovery Cities event in Gothenburg, Sweden.



Sobar – could be a way to foster this. A recovery café is a social place where people can support each other in their recovery journey. Because the café aims to promote social integration and broaden social networks, it is open to everyone – people in recovery, volunteers and the general public. Activities such as social and hobby groups, recovery-support groups and training programmes to become recovery coaches are also regularly organised.

An inclusive city also has a focus on meaningful life and social roles, such as access to meaningful jobs. A city could therefore work together with employers to foster certain skills, promote apprenticeships and create access to worthwhile employment, and inspiration for setting up such an initiative can be found in Blackpool's Jobs, Friends and Houses project.

So, how do you become an inclusive city? It's a process that takes time, and even small steps – mostly focusing on making recovery visible in the community by raising public awareness – are steps in the right direction. The role of the community could include the provision of mutual aid, peer support and educational campaigns, establishing inter-sectoral partnerships to promote social inclusion, carrying out activities and setting up structures to change attitudes and reduce stigma, providing incentives for employers to employ people in recovery, and implementing anti-discrimination policy. Our initiative is an indication that there is a growing momentum that we are tapping into and bringing together from its disparate roots.

Of course, no plan for inclusive cities can have any chance of acceptance and implementation without a positive mind-set and the buy-in of key stakeholders involved in local government and local community connectors – the 'go-to people' who live there. So the first step is bringing together key people from organisations responsible for employment, housing and social welfare in each city to make an overview of existing practices (community asset mapping), as well as to identify current gaps.

They will also define the city's mission, vision statement and related – short-term as well as long-term – goals and actions to support recovery, in line with the available resources and the people's needs. People in recovery, as well as their families, will be included in defining these actions, leading to services being tailored to their needs. The second step is implementing the identified actions, while monitoring and evaluating the process.

A recent recovery cities event in Sweden hosted by the City of Gothenburg began a process of recruiting community connectors, key citizens and early adopters to support this process in the local delivery of well-connected recovery communities. Inclusive cities was also presented at a 'recovery cities' side event at the recent Commission on Narcotics Drugs (CND) in Austria. The event highlighted the advantages of joint cooperation and partnerships, with the CND seeing more than 2,400 participants from 140 countries.

By building a learning set of cities across Europe, the idea of inclusive cities can be implemented and tested in practice. When several cities engage with the idea of inclusive cities, ingredients and – hopefully – good practices to improve social justice and community engagement can be shared.

The full published paper is available at:-
https://www.tandfonline.com/doi/full/10.1080/16066359.2018.1520223
Ted Talk at https://www.youtube.com/watch?v=GKTbAZCF4e0

David Best is professor of criminology at Sheffield Hallam University
Charlotte Colman is professor in drug policy and criminal policy at Ghent University
Stuart Green is service manger at Doncaster Aspire

A space to GROW

We are failing to reach women, connect with them and provide a safe environment in treatment, hears **DDN**

Drug-related deaths among women are the highest since records began. In the decade since 2006 there was a 95 per cent increase in women dying as a result of drug misuse, meaning that 697 women lost their lives in 2016.

So what's going wrong and where are we failing? And how can we turn this situation around? At a meeting of the Drugs, Alcohol and Justice Cross-Party Parliamentary Group, speakers were asked to give their thoughts on how we can break down barriers to improve women's access to treatment.

'Abuse and violence are underpinning problems,' said Jessica Southgate, policy manager at Agenda – the Alliance for Women and Girls at Risk. In many cases women's substance misuse was likely to be intertwined with violence, criminal justice and mental health issues and linked to hidden violence and trauma.

'Drugs are often used as a way to numb the pain of trauma,' she said. 'Women often end up in abusive relationships and remain in them because of their dependencies.'

Among the population of women prisoners, it was found that 66 per cent had committed offences to buy drugs and 48 per cent had offended to support the drug use of someone else (compared to 22 per cent of men). As well as abuse and trauma, recurring themes in the lives of women facing addiction were poor socio-economic circumstances and strong feelings of stigma and shame, which could include specific cultural disapproval among BAME communities.

The many complicated reasons that women turned to substance misuse meant that getting them appropriate help could be extremely difficult.

'Women substance misusers typically have complex needs and are often overlooked in service provision and policymaking,' said Southgate. As well as being overlooked in mainstream services they could also find themselves in 'intimidating spaces', particularly if they had experienced violence in their relationships with men.

Her organisation, Agenda, had partnered with AVA (Against Violence and Abuse) to produce Mapping the Maze – a project looking at the provision of services for women across the sectors of substance misuse, mental health, homelessness, offending and complex needs in England and Wales. They found that only 19 areas out of 173 in England and Wales had services that addressed all of these issues, and that most services only tackled a single issue. Many services were focused entirely on pregnant women or those with young babies, while provision for BAME women was extremely rare. There was nothing at all specifically for LGBTQI, those with disabilities, or refugees and asylum seekers.

While funding cuts and contract requirements were found to be serious obstacles to delivering good and effective services, the Mapping the Maze model was being suggested as a framework for developing effective interventions.

'Service design is one of the key pieces from evidence,' said Southgate, and this included making sure staff were trained to look for, recognise and understand issues relating to multiple disadvantage and the impact of trauma, particularly in terms of violence and victimisation.

Talking to women who were affected had revealed that getting the right help could be extremely difficult and could take a long time where services did not link up. Drugs were often used to numb the pain of trauma, she said, and it was important that all the appropriate support services were primed to help.

A collaborative approach with women worked best in understanding the links with substance misuse, asking their opinions and valuing the 'lived experience' of peer support. At the moment, women were being 'systematically excluded' as 'so often policy is made in silos', she said, when we needed to 'put women's voices at the heart of it'.

DOES YOUR SERVICE RUN SPECIFIC SUPPORT FOR WOMEN?

Do you have ideas on what would make a difference?

Please email the editor, claire@cjwellings.com

Having been in the sector for 20 years, Addaction's executive director of external affairs Karen Tyrell wanted to talk about some 'long-standing issues'.

'Drug and alcohol services have failed to meet the needs of women,' she said. 'We inadvertently create barriers.' There was a perception that women didn't need services as much as men, but they actually had more complex needs. 'They are often deeply concerned about social services getting involved and taking their children away,' she said, and 'they often don't have positive experience of authority figures'.

Women in Addaction's services had nearly always experienced some kind of trauma, she explained, and it wasn't 'a simple relationship between childhood experiences and drug use'. Many had been abused by a partner.

Services needed to enquire carefully about individual experiences and look for trauma symptoms. 'Our job is about taking a strength and resilience-based approach – changing it from "what's gone wrong?" to "what's happened to you?",' she said.

First impressions of treatment were important, and the experience could be negative if the first person they saw was male. Making progress also depended on understanding the level of stigma many had experienced – 'what kind of a mother are you?' – which tended to be very different from the attitude towards a dad who used drugs and alcohol.

'The fear of having children taken away can't be underestimated,' she said, and there was much to be done in becoming trauma and gender aware. Safe spaces for women were not just 'nice to have' services that could be cut first – they were vital and must be protected.

'I'm fed up with women's provision just being through the lens of childbirth and childcare – we have got to change,' said Tyrell. 'We need to demand more from each other as treatment providers. There must be ways we can work together differently.'

'Service design is one of the key pieces from evidence... so often policy is made in silos.'

Jessica Southgate

'I'm fed up with women's provision just being through the lens of childbirth and childcare.'

Karen Tyrell

Kim Morris, Addaction's North Somerset Women's Group coordinator felt that women represented 'a section of society that we're not reaching effectively'. She recently started a group to let women explore relationships and improve self-esteem and self-awareness, looking at trauma through the context of adverse childhood experiences (ACE). Substance misuse was 'the red herring' – not the root cause of problems, but an effect.

Providing a safe environment for discussion gave the opportunity to talk about all kinds of issues that could be barriers to treatment, such as fear of being judged, socially ingrained sexism, lack of faith that life could be different, and being dubious of the support that services could give them. The idea that services were 'the enemy' could be intensified by previous experiences with social services, particularly if children had been taken away from them.

Morris described how the group was helping women to grow in confidence and develop 'a greater sense of honesty and behaviours'. Trainee social workers were encouraged to sit in on the group and this further contributed to helping relationships. 'I have learned to stop blaming myself and apologising for everything,' one group participant had commented.

There was a lot to do, said Morris – the 'Orange Guidelines' only mentioned women in relation to pregnancy. But there was a growing interest around the group, and although it had started small it was going well and now needed commissioners on board.

'All services need to commit to being gender informed,' she stated. 'We need to ask about barriers and be open to listening about what would make a difference.' **DDN**

REPAIRING THE DAMAGE

Services can't ignore the links between childhood trauma and substance use, according to **Bill Say**

LET'S TALK ABOUT ATTACHMENT THEORY. The correlation between early childhood neglect and abuse (trauma) and heroin dependency is one of the most powerful in the field of social research.

This is not to say that all people who experience childhood trauma will become problematic substance misusers, nor is it saying that all substance misusers necessarily have had difficult childhoods. However, there is certainly a demonstrable link between the two. To understand substance misuse as more than simply a choice, bad luck or habit, we must include the important variable of our early childhood attachment patterns.

'Most substance misuse issues can be traced to pain and trauma, and the effectiveness of substance misuse services hinges upon finding alternative ways of managing the existential crises of suffering and trauma.'

So what is an attachment pattern and how are they formed? Bowlby, a prominent psychologist, postulated that our relationship with primary caregivers – particularly during times of distress – forms the basis of all future relationships, and this becomes most apparent when those relationships are fractious or challenging. A crying baby is essentially saying 'something is wrong, can you come and help'. We cry when we are in pain and that pain can be physical or emotional. Being sad, being angry or being scared, hurts. A nurturing caregiver will, in the most part, be able to alleviate that pain by feeding, wiping, burping or simply hugging and reassuring that child that they are not defenceless and alone.

Every time the pain alleviation occurs we strengthen a neural pathway in our developing frontal lobe that eventually will enable us to know that pain is temporary and can be alleviated – either through our developed emotional resilience or through turning to others for support. In Bowlby's terms, this is a securely attached child and thus an emotionally mature and emotionally resilient adult. But, what happens when a child's needs are not met?

The child cries and no one comes. If this happens often, it is neglect. A child's cry is a distress signal, and that distress will become louder and louder until eventually it stops. As we get distressed or are in pain or scared our bodies automatically go to fight or flight mode (the autonomic sympathetic nervous system). We are releasing adrenaline, and when we are soothed we go back to business as usual and return to normal human functioning. This includes release of growth hormones, digestion, blood filtration, emotional and cognitive learning and, most importantly, the ability to love, nurture and safely get close to others without fear of rejection.

So what's happened to that crying child who has stopped crying? That child, due to neglect, has simply given up asking for their needs to be met. That child will have come to a conclusion about their basic human needs, which can only be 'my needs are not important, therefore I am not important, I am worthless'. When they stop crying they enter the 'freeze' condition, which is the body's way of saying that you cannot sustain this flood of adrenalin forever. The child will disengage, not ask for help, think of themselves as less than others, and resign themselves to a life where the world is dangerous. In essence they either get angry with the world and go to battle with it, or withdraw – fight or flight. These neural pathways become locked in, and these become our truths.

How do we exist with pain? We can't reach out to others and we don't have the resources to cope ourselves. So the first time we try heroin, coke, alcohol, we get a flood of endorphins. That's what heroin does – it's an endorphin replicant, and it removes all the pain of loss and fear and anger that we've carried our whole lives, without ever knowing anything else. It feels magnificent and we feel whole again – do you think we might use it again?

When the primary caregiver soothes our pain we develop our pain tolerance and our pain endurance slowly with nurture – basically we are building our endorphin system. Most substance misuse issues can be traced to pain and trauma, and the effectiveness of substance misuse services hinges upon finding alternative ways of managing the existential crises of suffering and trauma, and finding meaning in belonging and real acceptance and understanding by others. And, most importantly, real understanding and acceptance of ourselves. Mental health and substance misuse must always be considered together.

Bill Say is partner at Just Say Training, www.justsaytraining.co.uk

HUMAN TOUCH

As Humankind and Blenheim merge, CEO **Paul Townsley** sets out how the new organisation is perfectly placed to meet the challenges ahead

I HAVE WORKED IN COMMUNITY HEALTH AND SOCIAL CARE PROVISION FOR OVER 30 YEARS NOW, from a young volunteer to my current role as CEO of Humankind. In that time, I've worked at large, medium and grassroots organisations, as well as within statutory provision.

As I approached my 50th birthday, I found my enthusiasm and sense of purpose is as strong as it has ever been. Largely because I enjoy working in my current role so much, and I am able to influence how my organisation best meets the needs of the communities we serve and responds to the most challenging times we have faced in my career.

I believe that Humankind is different from most organisations for two main reasons. Firstly, it has a range of health and social care services that address the needs of most people that need better opportunities in their lives. We help people maximise their potential and develop the skills required to live well and, wherever possible, to stand on their own two feet. Secondly, we work in partnership with small local providers and large private and NHS providers. We recognise that others are sometimes best placed to deliver services, whether that's in a locality or based on their expertise or size. We have always worked in this way. We only work where we know that our services will have an impact.

We're passionate about being the best that we can be, and we do this by keeping people at the heart of everything we do. This is one of the many beliefs and values that we share with Blenheim, and what makes us such a good fit together.

The merger with Blenheim has received an exceptionally positive response – from our staff teams, but also from our partners, stakeholders and the public. It was unthinkable ten years ago to have considered merging, but at this stage it makes complete sense. Why?

The simple answer is that it means both organisations can fulfil their almost identical missions to help vulnerable people have a fairer crack in society. By merging, we can do this from a much stronger position together. Furthermore, we have plans to develop new services to respond to people's needs, and to campaign for improvements that we believe will create a fairer society.

There is also a financial reason why we need to come together. Cuts to services and funding have made it increasingly difficult to provide support and help people reach their potential, at a time when the need is undeniably greater. As available funds reduce, commissioners are pushed to commission larger providers, and providers are pushed to become overly competitive. At the same time, we must comply with higher standards of quality and delivery.

Blenheim and Humankind merging is creating an organisation that will protect our partners in smaller organisations that know how to deliver in the communities they serve, and offer models that we know have an impact. We will do this not by acting in a predatory competitive way but by working collaboratively with those who have experience of our services, as well as funders and our partners.

To survive and thrive in the most difficult of times, and to deliver exceptional services, we must fight hard, collaborate with like-minded people, and take every opportunity to improve what we do. There must be an emphasis on impact over surplus, but we also need to ensure that our budgets are realistic but competitive, and yet allow us the resources to invest in staff and services.

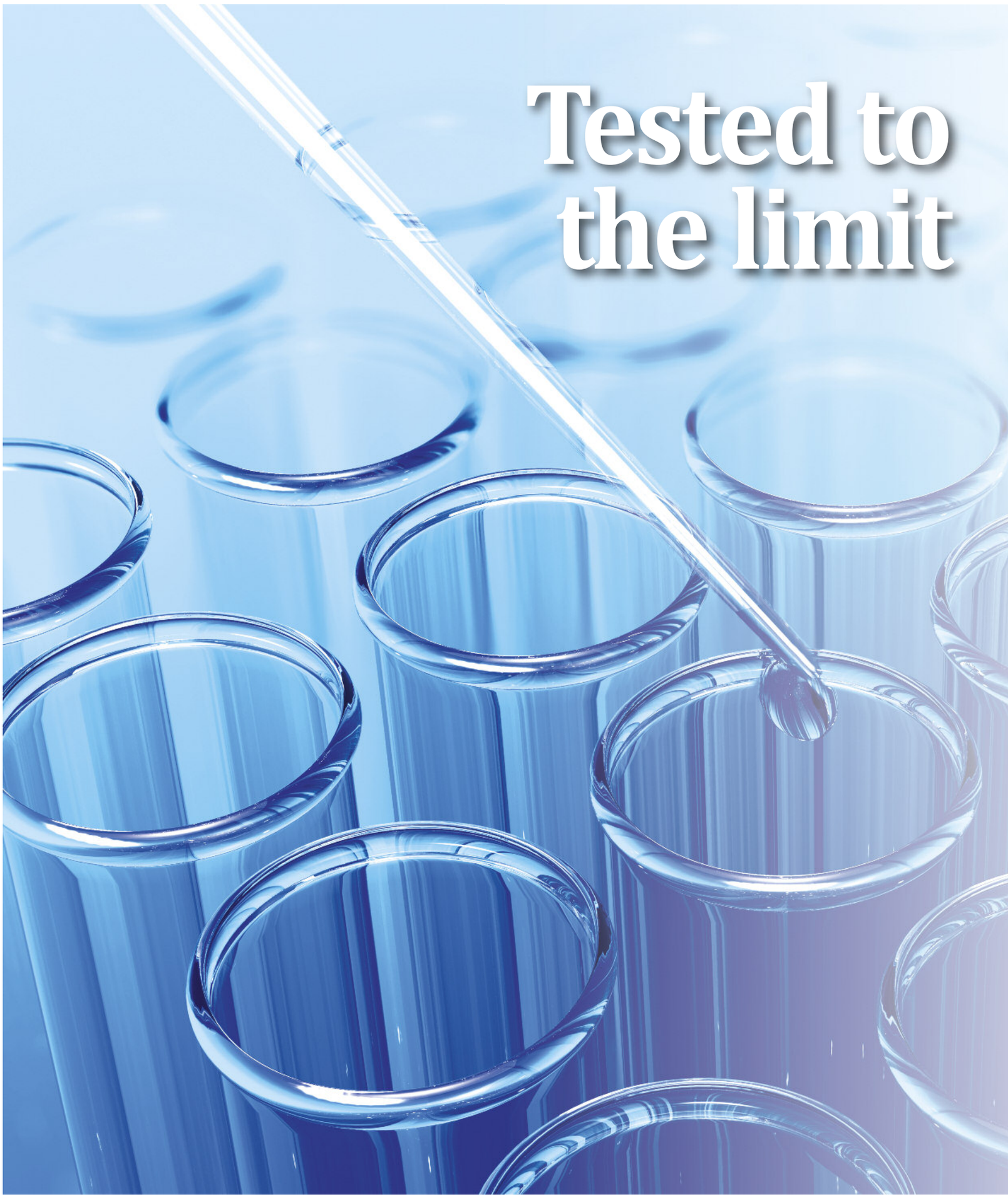
Our accounts will testify it is not simply about money but purpose for Humankind. All our interventions – particularly where we are co-designing them with service users, their families and carers, local communities and funders – save the state money, have a hugely beneficial impact and increase people's quality of life. Our ethos of putting people first will not change as a merged organisation; in fact, it's strengthened.

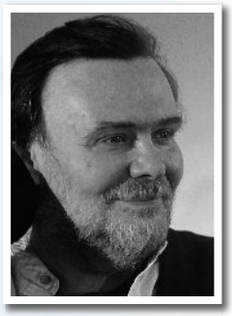
> 'Blenheim and Humankind merging is creating an organisation that will protect our partners in smaller organisations that know how to deliver in the communities they serve.'

As a newly merged organisation, we now have a combined 90 years' experience in supporting vulnerable people to reach their potential. As I have found when reflecting as I approached my 50th birthday and 30 years in the sector, at Humankind we are only becoming more energised to face the challenges ahead of us; to have a greater impact for our service users and their communities.

Paul Townsley is CEO of Humankind
You can find out more about Humankind on their website humankindcharity.org.uk

Tested to the limit





We need to talk about drug testing, says **Nick Goldstein**

Drug screening toxicology is the technical analysis of biological specimens to detect the presence of specific parent drugs or their metabolites. That's the dictionary definition and although hair, blood and saliva are also occasionally used for testing, the gold standard and most common biological specimen used for testing is urine, leading to the less rarefied label of 'piss test' – or 'whizz quiz' for our American associates.

Urinalysis has been around for a while. The ancient Chinese used it as a primary diagnostic tool and in ancient Greece, Hippocrates was incorporating Sumerian and Babylonian ideas of urine analysis from 4000BC into his theory that urine was a filtrate of the humours. (He was, amazingly, right about urine – if a little off with the humours.) It took Galen in 6AD to link urine to the blood and create the modern scientific concept of urinalysis.

So, urinalysis has been around a long time and like everything in life, its philosophy and purpose has changed and morphed to reflect societal development and changing needs. Cheaper testing kits, an intolerance of drug use and misunderstanding of intoxication have resulted in what was once an essential, medical diagnostic tool morphing into a monster tool of social control with tentacles in every area of society, ranging from pre-employment and employee drug testing, to concerned parents drug testing their children, to mandatory probation and children's social services drug testing. A couple of minutes googling 'drug tests' illustrates the scope of urinalysis in the 21st century.

As ever, substance misuse treatment is a mirror of wider society and the same increase and misuse of urinalysis can be found in the treatment system. It first appeared for service users shortly after the 1971 Misuse of Drugs Act and when I first arrived in treatment 15 years later, its role hadn't changed much. It was, then, mainly used at the start of treatment, during titration, when the user and their state of addiction were unclear. After the user had adapted to OST and had formed a relationship with their treatment service, urinalysis was rarely used and when it was employed it was for a clearly defined, specific purpose.

However, in the last decade the use of urinalysis has exploded in substance misuse treatment services, with testing becoming the norm at every appointment and by request. A sizeable amount of money is now going towards it, which could be better spent elsewhere.

Call me cynical, but I believe the two major drivers in the increased use of testing are cost and changing philosophy. The cuts of the last decade have significantly impacted on the recruitment and training of key staff, lowering the quality of frontline drug workers. Urinalysis testing has become a cheap replacement for less invasive methods of assessment and a fig leaf for the lack of clinical judgement.

It should be pointed out to policy makers and service commissioners that the use of urinalysis is a false economy, because it comes with a hidden cost – the quality of relationship between service user and service. It's hard to view this relationship as therapeutic when you're constantly being tested by rote and every test is the equivalent of the service saying, 'I hear what you're telling me, BUT I don't believe a word you say. So, I'm going to pay more attention to your bodily fluids than the words from your mouth, because my clinical skills are so poor and I have no other way of ascertaining what might be going on with you.' Getting tested for no good reason is demeaning at best and dehumanising at worst. It most certainly isn't therapeutic.

It would be remiss to suggest there isn't a role for urinalysis in treatment in wider society. In treatment there are plenty of people who actually like the extra discipline that comes with frequent testing – and who wants to get on an aeroplane with a stoned pilot? The problem is drug testing has spread far beyond its original, suitable role and become a cheap tool of behaviour modification and control.

Which brings us to the change in core philosophy that filtered in with the coalition government and their 'Roadmap to Recovery' agenda. Back in the day, treatment was seen as successful if it improved the life and health of the service user. Non-compliance wasn't a hanging offence and would be met with a discussion of what could be done to help the service user. Remember that? Well, things are very different now, even if compliance is slowly replacing abstinence as the sole purpose of treatment. Substance misusers are now just one of several vulnerable communities who've seen their services turned into hostile environments for political ends.

This hostile environment has reduced the number of users accessing treatment and reduced time spent in treatment, which might look good on paper, but is far from a 'positive outcome' for service users in the real world.

The change in philosophy is summed up by an anecdote a friend told me. After her service was recommissioned to a recovery-orientated service she was tested before her first appointment and it came back positive. This failure led to her key worker observing that maybe she should think about leaving treatment because it wasn't working for her. Obviously, this motivated her to make sure her next test came back negative – whereupon the key worker suggested that she should think about leaving treatment because the treatment was working! Amazingly she's still hanging on in treatment – no thanks to her treatment provider.

> 'Back in the day, treatment was seen as successful if it improved the life and health of the service user. Non-compliance wasn't a hanging offence'

So here we are; vulnerable users' treatment services have been morphed into a hostile environment for political ends and blanket urinalysis drug testing has been one of the major instruments of that change.

To add insult to injury, the reliability of drug tests has long been questioned and there's plenty of anecdotal evidence of both false positives and negatives, but it's hard to access meaningful statistic data on reliability. Whatever the reason, an area of silence has been created around the subject; it should be a national scandal that major decisions affecting people's lives are taken on the back of such questionable results.

We need to talk about this now because, as ever, more change is coming and if we don't have a conversation about drug testing in treatment and wider society the issue will only spread like a fetid puddle of urine.

As it is, substance misuse services are becoming cheap, low quality, one size fits all. If you don't fit you're gone, and if we leave the EU and more importantly its Social Chapter, one of our main lines of protection relating to both drug testing and wider substance misuse treatment will end and really radical change could become possible. As it is, we live in a world where highly questionable drug testing decides our liberty, employment and treatment among other fundamental aspects of our lives, and the situation will only deteriorate without some sort of intervention.

Coda – within a few days of writing the above I noticed an article that suggested the future of drug testing will be intelligent fingerprinting which analyses the chemicals secreted in a subject's fingerprints – a new 'non-invasive and dignified' means of testing, according to the manufacturer. While it's good to see that even those involved in drug testing realise how soul destroying urinalysis actually is, it's sad to see the technology remorselessly advancing without any debate on why we drug test and what we hope to achieve with it.

Nick Goldstein is a service user

More good practice stories at www.drinkanddrugsnews.com

Above: Faye McDonnell from Wellbeing Enterprises (centre) works with Knowsley Housing Trust's housing team.

BUILDING CONFIDENCE

Offering courses to housing trust residents is proving an effective way of giving mental health and wellbeing support

An initiative between a housing provider and a community social enterprise is offering mental health support to residents. Knowsley Housing Trust has teamed up with Wellbeing Enterprises to offer an innovative approach to staying well and tackling life's challenges.

Residents are offered a range of courses that are designed to help them cope with stress, build confidence and enhance motivation.

'We know over 5,000 of our residents receive mental health related benefits, so we're keen to support customers in dealing with day-to-day problems, improving confidence and learning new skills to increase motivation,' said Leann Hearne, group chief executive of Knowsley Housing Trust.

Staff are trained to direct residents towards practical help where needed – to deal with stress around budgeting related to Universal Credit, for example. Alongside stress management, other 'social prescriptions' on offer include life skills courses, interest groups, emotional awareness, creative crafts, volunteering, sleep and relaxation, singing and comedy and mindful movement.

The courses are to enable people 'to become strong enough to handle any of life's challenges', says Mark Swift, chief executive of Wellbeing Enterprises. 'Our process starts with a confidential conversation, then a practical plan is developed, and we connect our clients to professionals offering practical and professional support.'

THE RIGHT DIRECTION

Working closely with young people is deterring them from future crime

Oldham Youth Justice Service, the only youth offending service in England and Wales to be contracted out to a charitable trust, is achieving impressive results in moving young people away from further offending.

Inspectors found that staff were 'respected, skilled and highly motivated', with a deep understanding of the children and young people that they worked with and involving them at every stage of the process.

Special mention was given to positive initiatives in relation to BME communities, with work now taking place to find out why a disproportionately high number of children from BME backgrounds are given custodial sentences. Projects for restorative justice were also credited for their impact, with young people and their parents shocked at the impact on victims of their criminal behaviour.

'Their work to support young people to move away from further offending was very strong,' said chief inspector of probation, Dame Glenys Stacey. 'Staff put a lot of emphasis into building relationships and engaging with young people, for example in developing Oldham's violent youth crime strategy... there is a recognition that long-term desistance from offending is more likely to be achieved if children and young people's wider needs are met.'

> 'Staff put a lot of emphasis into building relationships and engaging with young people.'
>
> DAME GLENYS STACEY

MAKING AN IMPACT

A new business network is giving a valuable boost to entrepreneurs

A social investment fund has been set up to help enterprises that employ ex-offenders and people in recovery from addiction.

The Forward Trust launched its Forward Enterprise Network in February to show mainstream businesses and the general public the value of people from both of these groups. The social entrepreneurs who make up the network have benefited from a share of the £2m Forward Enterprise Fund and are now able to share knowledge and funding tips with other members, as well as forming new business relationships.

'Young entrepreneurs often feel alone, but they now have a network of peers to share successes and challenges,' said Mathilde Duteil, enterprise manager for The Forward Trust. Among the confidence-boosting advice was the shared experience of loan applicants of going through the investment process and presenting to the Investment Committee.

'Today's launch showcased the ups and downs of starting a social enterprise by the people who have worked on their ideas from behind the door,' said LJ Flanders of Cell Workout CIC, one of the businesses supported by the fund. 'The social impact everyone is making is invaluable.'

Below: Forward Enterprise Network launch.

HOW DO WE GET MORE FOR LESS?

As deputy drug czar for the Blair government, **Mike Trace** oversaw the expansion of today's drug and alcohol treatment system. In the fourth of his series of articles, he gives his personal view of the successes and failures of the past 20 years, and the challenges the sector now faces.

In my last article, I offered to make some suggestions on how the drug and alcohol treatment sector can respond to the current 'perfect storm' of increasing demand and reducing resources. In a situation where there is insufficient political support, at central or local government, for a big increase in resources for treatment, we have to find ways of achieving better outcomes for less funding.

The first thing we need to do is get much better at focusing the available resources on delivering the outcomes that matter. This is a challenge to the commissioning and procurement system. Start by defining the desired outcomes much more clearly – the ones that matter to our clients and the community (and therefore politicians) are reductions in drug-related deaths, infections and offending; and increases in purposeful activity, secure accommodation – and family stability.

Each of these are definable and measurable but, 20 years after we established our national treatment system, these outcomes are not routinely reported on in national data systems, few commissioning decisions are based on evidence of their achievement, and few providers bother to conduct research on their achievements against them. I thought we would by now have developed a clear bank of evidence on the extent to which local treatment systems achieved these outcomes and the extent to which individual providers or models of service deliver the desired results.

Instead we have a very thin outcome evidence base, which is a real failing after billions of pounds of investment. This leads to two major problems – it undermines our ability to demonstrate value for money to politicians and taxpayers, and it leaves procurement decisions to be made more on a bidder's ability to write good bids or manage good processes, rather than on their ability to deliver outcomes.

Secondly, we need to be much better at stimulating behaviour change among our clients, rather than just managing the impacts of continuing high-risk patterns of consumption. Of course, the first behaviour change is towards safer using and engagement with services, but we need to move quickly towards motivating clients to believe they can make changes in their drug use and wider lifestyle, then offering them support and practical help to make those changes.

When people with a history of drug/alcohol dependence are able to make these changes (what we all refer to as 'recovery'), there are massive benefits for them, their families, and the community. There is also the benefit that pressure is relieved on the overstretched system – people in good recovery make less use of drug/alcohol services, wider health services and social services. They also cease to be a burden on the criminal justice and benefit systems.

Next, we have to be brave enough to do less of something. The demand has increased – from the diversification of drug problems (no longer just daily heroin/cocaine use) and the (perfectly sensible) addition of primary alcohol users to the system. And the resources are reducing – around 20 per cent in the last four years, with most informed opinion predicting that this trend will continue in the next few years.

So, what can we do less of? My focus would be on reducing the paperwork and bureaucracy involved in substance misuse case management – these systems have been built up over many years, and have good reasons for existing, but it cannot be right that scarce face-to-face client time is largely taken up with filling in forms and populating databases. We need to make the client/worker interaction more human again.

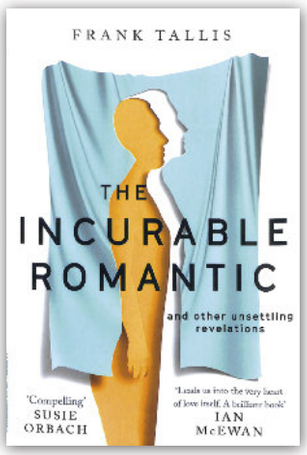
Linked to this, we must lose the obsession with doing a little bit with everyone and get better at focusing resources on where we can make a difference. Most services are commissioned on the basis of engaging with the maximum number of clients at minimum cost. This inevitably leads to low intensity provision for most people, when we know that most of them will need deeper help to tackle the social and psychological challenges that have brought them into services. We need to be brave enough to put less effort into those not willing to engage and more into those who are open to changing their behaviour.

'It cannot be right that scarce face-to-face client time is largely taken up with filling in forms and populating databases. We need to make the client/worker interaction more human again.'

Finally, we need to reposition the treatment sector in the machinery of government – with greater health and social focus, but getting back to the original aim of convincing politicians that our sector delivers true cross-sectoral benefits. More about that next month.

Mike Trace is CEO of Forward Trust

The Incurable Romantic and Other Unsettling Revelations



The Incurable Romantic and other Unsettling Revelations, by Frank Tallis
ISBN: 978-0349142951
Abacus (paperback), £9.99

Anyone who has attended a sex and love addiction meeting knows that when natural human instincts and emotions run out of control, they can cause deep distress. Psychotherapist Frank Tallis skilfully illustrates a full and often extreme range of such cases, including a paedophile who would 'rather die' than act out his obsession with a six-year-old girl.

Intimate relationships are often problematic for people who've been addicted to alcohol and other drugs. Don't get involved with anyone in your first year clean and sober, is an advice mantra. Recovery needs time to replace self-loathing and consolidate what Tallis terms, 'a sense of one's own identity'.

'He reminded me of an addict,' the author says of a client who has been rejected, 'the sudden withdrawal of the object of his desire made him profoundly depressed', there was a 'shivering enfeeblement'. Just as someone in early addiction might not see any downside to their drug of choice, he idealised the woman he loved as a goddess, with only adorable traits: a fixation.

Love is always fuelled by endogenous 'drugs': dopamine, phenethylamine, oxytocin and testosterone. Sex involves 'compounds that resemble amphetamines and opiates, with hormone rushes as addictive as street drugs', while 'the psychoactive substances released into our bloodstream when we are aroused can take us out of time and make us feel boundless and eternal'.

In The Woman Who Wasn't There, a female client is utterly convinced her male partner is having an affair. She checks the bed for tell-tale 'stains, hairs... picking them off the sheet and holding them under a lamp'. She is diagnosed with Delusional Disorder: Jealous Type. The man denies her 'oppressive' suspicions. 'Was he telling the truth?' Tallis thinks so, but his is not an exact science and 'I could be wrong'.

The Man Who Had Everything is a rich young entrepreneur who definitely hasn't been honest with his wife. She finds out he's seen prostitutes. It's actually more than 3,000. He takes escorts to candlelit dinners and shows them round big houses as if they were buying together. He's addicted to being fallen in love with. Then he wants to do it all again, with someone new.

> Don't get involved with anyone in your first year clean and sober... Recovery needs time to replace self-loathing.

Tallis has a likeable writing personality, willing to admit mistakes: 'I had become an inquisitor, and the rapidity of my questions made him uneasy'. He tightly weaves his attempts to help manage abnormalities with fascinating historical and theoretical background. It works perfectly. We also get to know the author, including his own love-life failures. He seeks 'the thrill of the uncanny' (which is also a celebration of diversity). 'Abandoned' is a frequent word here. There are people who have been left adrift, sometimes by an untreated repressed childhood memory. Tallis also loves going to abandoned places, especially 'wandering around old asylums, looking for curiosities'.

This essential book leaves few crevices of the human mind and body unattended to.

Review by Mark Reid

MEDIA SAVVY

The news, and the skews, in the national media

> 'It's reignited the debate on the ways violent crime is linked to a rise in cocaine use.'

THE SENSELESS SLAYING OF 17-YEAR-OLD JODIE CHESNEY in an Essex park a week ago shocked Britain. Not only has it shone a spotlight on the country's spiralling knife crime epidemic but it's reignited the debate on the ways violent crime is linked to a rise in cocaine use – and how the 875,000 Brits who take it each year could be complicit in her death.
Rebecca Evans, *Sun*, 9 March

MANY OF THE PEOPLE I KNEW FROM NA ARE DEAD. Some relapsed and overdosed. Some killed themselves. Some died of Aids and hepatitis C. Others have died of heart disease and cancer: a far higher mortality rate from natural causes than among those I know who weren't addicts... I am one of the fortunate ones. Sure, I've worked hard at my recovery, but I have been lucky to have people in my life whom I adore and to have been able to make a career out of doing a job I love. Yes, it would have been nice to have enjoyed it all a bit more – I tend only to recognise happiness as the absence of pain – but you can't have everything. I'm still here and that's the main thing.
John Crace, *Guardian*, 25 March

CLAIMING THAT ADDICTION IS A DISEASE is not only scientifically baseless, it hinders rather than helps many addicts because it undermines hope. It makes them believe they do not have agency over their condition, that they are helpless in the face of a greater force. Whereas they are the only ones who can help themselves.
Jan Moir, *Mail*, 8 March

NO, NOT EVERY MARIJUANA SMOKER GOES OUT AND KILLS. So what? Not every boozer gets into fights, or commits rape, or kills people with drunken driving. Not every cigarette smoker gets cancer or heart disease. But we act against these things because of the significant minority who do cause or experience these tragic outcomes. And almost all of those who go out and kill someone with a blade will turn out, once the investigation is over, to be a long-term user of marijuana, no longer wholly sane or wholly civilised. Its widespread use is the only significant social change in this country that correlates with the rise in homicidal violence.
Peter Hitchens, *Mail on Sunday*, 11 March

change,
grow,
live

Could you help people achieve their potential?

Change Grow Live (CGL) offers a wide range of employee and volunteer opportunities which can encourage behaviour change, improve health and relationships and make a real difference to people's lives. We currently support 66,000 people each day.

We value creativity and initiative and you will be encouraged to contribute your ideas to the development of our substance misuse, health and social care and criminal justice services. We work with adults, young people and families and roles include nurses, recovery workers, service managers and team leaders.

We offer employees:

- A professional and supportive environment
- An hour a week to spend doing something positive for your personal wellbeing
- A competitive salary
- 25 days annual leave (rising to 30 days per annum)
- A generous contributory pension scheme
- Personal and professional development, including training courses, mentoring programmes and time off to pursue relevant qualifications.

Volunteers can also gain valuable experience and many of our volunteers go on to gain paid roles.

We are an equal opportunities employer and hold the prestigious Investors in People Silver award.

For further information about the roles we have available please visit www.changegrowlive.org/jobs

CHANGE GROW LIVE

Our mission is to help people change the direction of their lives, grow as a person and live life to its full potential.