DRINK AND DRUGS NEWS

DDN

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# GREEKS BEARING GIFTS

## CAN CLASSICAL PHILOSOPHY TEACH US ABOUT ADDICTION?

**INSIDE:** Dr Edward Day, the government's new drug recovery champion

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## EDITOR'S LETTER


pic: nigelbrunsdon.com

Twenty years ago substance misuse treatment was a government priority, with a 400 per cent increase in investment (page 16). A decade ago the government-funded Drug Interventions Programme was diverting many people away from the criminal justice system and into education and treatment programmes (page 14). Since then disinvestment has become the norm.

So where does that leave us? In dire need of a clear harm reduction led strategy to replace a 'tough on drugs' approach that is unfit for purpose in every way, according to a parliamentary meeting that included senior police and highly experienced policymakers.

The government's newly appointed drug recovery champion is a welcome arrival, promising a listening ear, a strong voice, and a commitment to tackling stigma and prejudice around people who have had problems with drugs (page 8). His professional experience will certainly bring an informed view to the home secretary's drug strategy board, and it is encouraging that he is already a keen supporter of service user involvement and peer-led recovery communities.

Meanwhile, far away from Westminster, we're continuing our quest for new and interesting approaches to understanding addiction and in this month's cover story Albert Yates offers a fascinating journey into Classical Greek philosophy. Could Socrates teach us a thing or two about nurturing the soul?

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


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# SCOTS RECORD HIGHEST EVER DRUG-RELATED HOSPITAL ADMISSIONS

**SCOTLAND HAS SEEN A FOURFOLD INCREASE** in drug-related hospital stays in the last 20 years, according to the latest figures from the Scottish NHS. Rates have increased from 51 to 199 stays per 100,000 population, with a 'sharper increase' seen in recent years.

In 2017-18, there were more than 10,500 drug-related general acute hospital stays in Scotland, the highest figure since records began. This related to nearly 8,000 patients, more than half of whom were 'new'. Nearly 60 per cent of drug-related general acute hospital stays were the result of opioid use, while more than half of drug-related psychiatric hospital stays were associated with 'multiple/other drugs', including solvents, stimulants and hallucinogens. The 35-44 age group was the most represented in both types of admissions, with drug-related general acute stays for this group increasing more than tenfold since the mid-1990s.

Admission rates for 15-24 year olds are also increasing, however, with the 2017-18 rate the highest in more than a decade. Around half of all patients with a drug-related general acute or psychiatric hospital stay lived in the country's most deprived areas.

'These figures are of great concern,' said Scottish Drugs Forum (SDF) CEO David Liddell. 'It highlights very clearly the need for greater and targeted interventions with this population both within the hospital setting and in the community, which can reduce unplanned hospital admissions. This will save the NHS resources and deliver a better service to people with a drug problem.'

There were examples of good practice however, he said, such as drug and alcohol nurse liaison posts based in hospitals. 'These posts aim to assist people in getting appropriate care while in hospital and help link people up with appropriate community based services.' The trend in increasing admission rates for younger patients was also 'worrying', he added, and mainly linked to cocaine and cannabinoid use.

Meanwhile, a report from Audit Scotland shows a 71 per cent increase in drug-related deaths in Scotland since 2009, with 76 per cent of fatalities now in the over-35 age group. The 2017 figure was the highest ever recorded, at 934 (*DDN*, July/August 2018, page 4), with the 2018 total – due to be published this summer – expected to be higher still.

*Drug-related hospital statistics Scotland 2017/18 at www.isdscotland.org*

*Drug and alcohol services: an update at www.audit-scotland.gov.uk*


'These figures... highlight very clearly the need for greater and targeted interventions'

DAVID LIDDELL

## COUNTERING CORRUPTION

**A NEW TASK FORCE TO TACKLE CORRUPTION in prisons and the probation service has been announced by the Ministry of Justice. The Counter Corruption Unit will address issues such as staff smuggling drugs and other contraband into prisons, and will be split into one national and five regional teams. 'A small minority continue to engage in corrupt behaviour in our prisons – damaging both the integrity of the system and their profession,' said justice secretary David Gauke. 'This unit underlines our determination to stamp out criminality in prison in all its forms and will make sure we are closing the net on the individuals driving this.'**

'A small minority continue to engage in corrupt behaviour in our prisons'

DAVID GAUKE

## COUNTY CRACKDOWN

**FIVE HUNDRED MEN AND 86 WOMEN WERE ARRESTED** for county lines-related activity in the week beginning 13 May, according to the National Crime Agency (NCA). The coordinated activity also saw 519 vulnerable adults and 364 children engaged for safeguarding, with more than 30 referrals as potential victims of modern slavery. The grooming techniques used by county lines gangs are 'similar to what has been seen in child sexual exploitation and abuse', states the NCA. 'We know that criminal networks use high levels of violence, exploitation and abuse to ensure compliance from the vulnerable people they employ to do the day-to-day drug supply activity,' said NCA's county lines lead, Nikki Holland. 'These results demonstrate the power of a whole-system response to a complex problem that we're seeing in every area of the UK.'

## DRINKING UP

**ANNUAL GLOBAL PER CAPITA ALCOHOL CONSUMPTION INCREASED from 5.9 to 6.5 litres per adult between 1990 and 2017, according to a study published in the *Lancet*. This is estimated to reach 7.6 litres by 2030, with the proportion of adults classed as 'heavy episodic drinkers' rising to 23 per cent.** *Global alcohol exposure between 1990 and 2017 and forecasts until 2030 at www.thelancet.com*

## CASH CALL

**A CONSENSUS STATEMENT** signed by more than 80 organisations including Collective Voice, Alcohol Change UK and the royal colleges of nursing, GPs and surgeons is calling on the government to increase investment in public health to reduce health inequalities. While local authorities had 'made efficiencies through better commissioning', cuts were affecting services, it says, adding that removal of funds from public health was 'a false economy'. *Statement at www.cancerresearchuk.org*

## DAY IN

**DR EDWARD DAY HAS BEEN APPOINTED AS THE GOVERNMENT'S DRUG RECOVERY CHAMPION, the Home Office has announced. Dr Day is a clinical reader in addiction psychiatry and has helped develop national clinical guidance for the substance field. He will agree an 'annual delivery plan for drug recovery' with ministers, support collaboration between partners such as councils, housing organisations and criminal justice, and aim to tackle issues such as stigma. 'His work will make a real difference to the lives of those suffering the misery of drug dependency,' said home secretary Sajid Javid.** *See feature, page 8*

## DRINKING CULTURE

**ONE IN FIVE IRISH ADULTS IS A 'HAZARDOUS' DRINKER**, with a further 23 per cent at risk of becoming one, according to a report from Drinkaware.ie. 'Within the findings is a deep-rooted and broad acceptance of excessive drinking as our cultural norm,' says the document, adding that most survey respondents had 'little or no' awareness of what constitutes low-risk drinking. 'The negative impact of alcohol in Irish society is widely known,' said CEO Sheena Horgan. 'Of particular concern is that these drinking habits appear even more embedded among younger people, with 64 per cent of under-25s stating that they often drink as a coping mechanism.' *Report at www.drinkaware.ie*

# BRITS 'GET DRUNK' MORE REGULARLY THAN OTHER NATIONALITIES

**BRITISH PEOPLE WHO DRINK GET DRUNK MORE REGULARLY THAN OTHER NATIONALITIES**, according to the latest *Global drug survey*. Respondents in the UK reported getting drunk 51 times a year, compared to an average of 33 times.

Participants from other English speaking countries such as the US, Canada and Australia also reported getting drunk regularly – at 50, 48 and 47 times a year respectively – while those in Chile reported getting drunk 16 times per year. Almost 40 per cent of participants who drank alcohol in the previous 12 months said they wanted to drink less in future.

The survey compiles from data from just under 124,000 people across more than 30 countries. Almost 60 per cent of respondents were male and 87 per cent were white, with a mean age of 29. Sixty per cent said they went clubbing at least four times a year.

Of the 20,000 people who completed the section on cocaine use, less than 9 per cent reported using the drug on a weekly basis, but 65 per cent said they'd used it up to ten times in the previous year. Just over 1 per cent had needed to seek emergency medical treatment following cocaine use, while more than 70 per cent of those who'd recently used it said they would support a 'regulated fair-trade' market, with most willing to pay more.

Use of MDMA powder, meanwhile, is now as common as ecstasy pills, although almost three quarters of people who took MDMA reported doing so on ten or fewer occasions. Use of the 'dark net' to buy drugs was also on the rise, with more than a quarter of people who'd bought drugs that way doing so for the first time in 2018. MDMA, LSD and cannabis were the most frequently purchased substances.

One third of female respondents reported having been taken advantage of sexually at some point while under the influence of alcohol or drugs, and 8 per cent within the last year – the rates for men were 6 per cent and 2 per cent respectively. Alcohol was involved in almost 90 per cent of overall cases.

Of the more than 52,000 respondents who completed the survey's policing section, almost a quarter reported that they had 'encountered police' in relation to their drug use in the last year, including stop and search, roadside testing and use of drug dogs. People in Australia and Denmark were most likely to have had dealings with the police, and those in New Zealand the least. Most people, however, had favourable attitudes towards the police, the document states. 'For example 50 per cent of respondents (who are all people who use drugs) said police frequently/somewhat frequently treat people with dignity and respect. But those who have been recently policed had less favourable attitudes, and were less likely to report they would help the police if asked.'

*Results at www.globaldrugsurvey.com*

Respondents in the UK reported getting drunk 51 times a year, compared to an average of 33 times


## STREET SCENES

**SUBMISSIONS ARE OPEN for this year's Recovery Street Film Festival until 1 August. Films should be no longer than three minutes, with prizes for the top three winning entries.** *Full details at rsff.co.uk*

## DOSE DECISIONS

**METHADONE DOSE OPTIMISATION is vital when treating people on opioid substitution programmes for tuberculosis (TB) and other conditions, according to researchers at Aston University in partnership with Addaction. Anti-TB drug rifampicin is known to increase the breakdown of methadone in the body, meaning that methadone levels need to be gradually increased and then decreased after the TB treatment ends, with a range of medications for HIV and epilepsy causing similar interactions. 'We found that rifampicin significantly alters the level of methadone in the blood and necessitates dose adjustments, with daily doses of almost double those commonly used in clinical practice required for optimal levels of methadone in the blood,' said Aston University's Dr Raj K. Singh Badhan.** *Study at www.journals.elsevier.com/drug-and-alcohol-dependence*

## OECD OPIOIDS

**OPIOID-RELATED DEATHS ACROSS 25 OECD COUNTRIES INCREASED** by more than 20 per cent between 2011 and 2016, according to an OECD report, with the rise most pronounced in the US, Canada, Sweden, Norway, Ireland and the UK. Opioid overprescribing is 'considered one of the most important root causes of the crisis', it says, with 240m opioid prescriptions dispensed in the US in 2015 – 'nearly one for every adult in the general population'. *Addressing problematic opioid use in OECD countries at www.oecd.org*

## CAPE CRUSADERS

**A NEW INITIATIVE TO HELP CHILDREN AFFECTED BY PARENTAL ALCOHOL MISUSE has been launched by the Children's Society. CAPE (Children of Alcoholic Parents Engagement) provides training, workshops and free online resources to help professionals identify children at risk and increase awareness and understanding. 'Having a parent or carer who is dependent on alcohol can be extremely distressing and isolating for a young person and have a huge impact on their welfare and wellbeing,' said Children's Society director of national operations Nerys Anthony. 'Our new CAPE programme is designed to give anyone who works directly with a young person the expert tools and knowledge they need to support them, so that these vulnerable young people are recognised and receive the support they need.'** *www.childrenssociety.org.uk/parental-alcohol-misuse*

## GAMBLING GAINS

**A COMPULSORY LEVY SHOULD BE PLACED ON THE GAMBLING INDUSTRY** to support people with gambling problems, according to a report in the *BMJ*. The paper also wants to see the 2005 Gambling Act revised and responsibility for gambling moved from the Department for Digital, Culture, Media and Sport (DCMS) to the Department of Health and Social Care (DHSC). There are currently 33m active online gambling accounts in Britain, with the extent and cost of UK gambling 'significantly' underestimated. 'Simply stating that gambling is a public health concern is not enough,' says the report. 'It must also be treated as one.' *Gambling and public health at www.bmj.com*

# HOLE IN THE

Looking to the philosophers can give us valuable understanding of the nature of addiction, suggests **Albert Yates**

On the face of it, Classical Greek philosophy and the psychology of addiction are not natural bedfellows. Bringing both disciplines together to produce a plausible theory of addiction might seem unlikely. However, this is less so when addictive behaviour is seen for what it is: human behaviour.

To better understand human behaviour, we would do well to acknowledge the work of our intellectual ancestors – Socrates, Plato, and Aristotle. These Classical Greek philosophers spent their lives trying to understand the way human beings behave. Choice, motivation, personal responsibility, desire, and excess are but a few aspects of human action they explored. In modern times, these are among the areas of human behaviour that practitioners in the field of addiction seek to understand.

# SOUL

Socrates thought differently. For him the soul was life itself.... It is the soul that governs the body. It guides us into action and carries us wherever we go. Reason and intellect constitute the essence of the soul, which is perceptible by reason alone.

In this article I offer a brief insight into how we may account for addiction (or to be precise, an excessive appetite) by understanding the characteristics of the soul as represented by Socrates.

## What I propose is:

**'Addiction is a disorder of the soul characterised by the excessive use of psychoactive substances, or the excessive involvement in certain non-substance related activities.'**

The way in which Socrates defined the soul in mid-fifth century BC is very different to the way we think of it today. In modern times, the soul is more likely to be thought of as a non-secular entity, relating to religious or spiritual matters. The idea that we are embodied souls, and more than just physio-chemical organisms, does not accord with current intellectual thinking. To consider the soul serving a practical purpose by moving us into action would seem incongruous to most people.

Socrates thought differently. For him the soul was life itself. The soul takes primacy and should be cared for over the body. It is the soul that governs the body. It guides us into action and carries us wherever we go. Reason and intellect constitute the essence of the soul, which is perceptible by reason alone. Socrates believed that the soul is something that keeps bodily desires and affections in check. These are the bare bones of Socrates' conception of the soul. They permit us to consider the soul within the context of addiction.

Through Plato's writing, Socrates tells us that the soul is made up of three parts. There is 'appetite', which can be thought of as base physical craving. Then there is 'reason or logic', the faculty that takes a considered view, and sets the right course of action. The third part is spirit, not to be confused with 'spiritual'. Spirit can be seen as anger, indignation, often an ally of knowledge.

When appetite is kept in check by reason, the soul is in a state of balance, a state of harmony. A happy and flourishing life can be expected when the soul is in this state. On the other hand, when appetite rules the soul and defeats reason, the soul becomes disordered. Appetite becomes unruly and if it is not checked, addiction ensues. A miserable, unhappy life, dominated by excess can be expected.

What has happened here is that the soul has become undisciplined, instigated by an excessive appetite. This reveals itself in the many problems commonly associated with addictive behaviour. We should bear in mind that each one of us has a worse and better element within our soul.

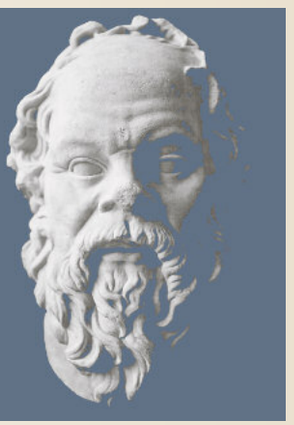
We might reflect on those occasions when we have allowed our desires or emotions to lead us to behave in a way that is out of character and not in our best interest. It may have been nothing more than a momentary lapse in an otherwise disciplined existence. There is nothing remarkable about this. Socrates believes that '...the mass of mankind lives an intemperate life because of ignorance or lack of self-control or both'. When this happens, it is because the worse part of the soul (appetite) has been permitted to overwhelm and control the good (knowledge and reason).

Appetite can develop to the point of excess, not because the individual is a moral failure, or is in the grip of a disease, but because they are human beings like the rest of us. The development of an excessive appetite could happen to any one of us.

Socrates tells us that the force that leads a person to develop an excessive appetite is the 'power of appearance'. The power of appearance fools us into believing that something bad is good. It has the capacity to encourage a person to do something, that, all things considered, they would not ordinarily choose to do. In other words, it persuades them to act against their better judgement. Think of being tempted into eating a cream cake when dieting, or being persuaded to have that last drink. When we succumb to such temptation the power of appearance has diverted attention from reason and logic, and set the soul on a course of fulfilling the senses.

The power of appearance can exert its influence on the imagination. Aristotle says that 'the soul never thinks without an image'. He adds that 'for the most part imaginings are false'. The choice between a good and bad course of action is offered by the imagination. From such an image the body is moved to act, which could lead to an unwelcome outcome for someone with an addiction. Aristotle's treatment of imagination helps us better understand why, in the event of the bad course being chosen, relapse in addiction occurs without any obvious triggers being present.

'Falling down is not a failure. Failure comes when you stay where you have fallen.'
Socrates



As human beings we are fallible, we are not perfect. Socrates tells us that the desires we experience can sometimes overpower reason. For someone trying to end their addiction, the inner conflict they experience between wanting to quit, but finding it difficult to do so, can be characterised by the struggle in the soul between knowledge and appetite attempting to assert control over the other. Such conflict can only be resolved if the soul is disciplined. For Socrates, discipline takes the form of 'fair words' or 'charms'. He sets great store by the therapeutic use of words. Today, we might draw parallels between fair words or charms and the talking therapies.

The bottom line is that the Classical Greek philosophers warn us that we cannot trust the body. As Socrates says:

> ...the body fills us with desires and longings and fears and imaginations of all sorts, and such quantities of trash, that as the common saying puts it, we really never have a moment to think about anything else because of the body.

The Classical Greek philosophers tell us that if we are to check unruly bodily senses and realise the truth, we must turn to the soul. A soul that is cared for will not deceive. It will not engage in excessive behaviour. Addiction is a disorder of the soul – a disorder that we can all succumb to if we care more for the body than the soul. That we fill the body with desires and longings, false imaginings, fears, and quantities of trash is perhaps a metaphor for addiction in the 21st century?

**Dr Albert Yates is author of *A theory of addiction founded on classical Greek philosophy*, a thesis at Manchester Metropolitan University**

# Brand New Day

**Dr Edward Day has just been appointed as the government's drug recovery champion. He talks to DDN about the challenges and opportunities of the new role**

'If I was going to pick one thing, it's still the stigma of drug use,' says Dr Edward Day of the challenges that his new role as the government's drug recovery champion will need to address (see news, page 4). 'There's a real job to do to break down the prejudice against people who've had a drug problem.'

A 20-year veteran of the field, he started out at what was then the regional addiction unit in Birmingham while still a junior doctor training in psychiatry. 'That really sparked my interest,' he says. 'It was a very different world back then – a 25-bed unit with an outpatient bit attached in the grounds of an old psychiatric hospital, and we had probably a couple of thousand patients who came from the whole of the West Midlands. You got a detox and relatively little else. But that patient group really spoke to me, and I decided that this was what I was going to do.'

After completing his PhD he became a consultant in an NHS drug service in Birmingham, and worked there until he started his current role as consultant psychiatrist at the Birmingham and Solihull Mental Health NHS Foundation Trust five years ago. He's also clinical reader in addiction psychiatry at the University of Birmingham, and now drug recovery champion on top – isn't that a lot to take on?

'Well, I've always had a clinical/academic role, so I've always juggled those two things,' he says. 'Half my week is spent doing hands-on clinical work and the research I do is all patient-centred, so the two feed off each other. It can be a challenge at times but the two sides of the job go hand in hand.'

He's also been heavily involved in shaping national

‘If I was going to pick one thing, it’s still the stigma of drug use. There’s a real job to do to break down the prejudice against people who’ve had a drug problem.’

policy, including the NICE guidelines for methadone and serving on the two ‘orange book’ working groups, as well as a substantial amount of teaching and stints as a trustee of Action on Addiction and Changes UK. While juggling all this can be difficult, it’s also advantageous, he says. ‘I’m quite often the only person in the room who can see both sides of the fence – academia and clinical services.’

## Recovery is defined by the person – I don’t think it’s my place to put a definition on it

The word ‘recovery’ is something that people have argued over – how would he define it? ‘Recovery is defined by the person – I don’t think it’s my place to put a definition on it,’ he says. ‘But I’d go along with the various attempts that really focus on trying to achieve control over substance use, good mental and physical health and, for want of a better term, citizenship – something to get up for in the morning, friends, family, job. I guess the contentious bit is whether the control over substance use means abstinence or not. If you want a straight answer then I do think the best outcomes I’ve seen are when people get abstinent, but to say recovery is only about abstinence is to dismiss all the other stages on the way to that, and I think that’s one of the difficulties.’

The field does seem to be less polarised, however, with some of those barriers breaking down. ‘Definitely, and I think perhaps the key task of this role is to try to move that forward. In those 20 years of my career, for the first ten years we went from a very low level of service – where people saw someone for maybe ten minutes every six months – to a lot of investment. The professional services really developed, and there was a lot of very good evidence-based practice that went in. I think the British system stands up around the world as one of the most evidence-based.’ While recent years have meant less money, one positive has been the ‘shift in emphasis towards peer-led abstinence-based recovery’, he states, ‘which I think was an element missing in the system in those early years’.

He’s always held the view that ‘the professional part is the base that sorts out the basic needs, keeps people alive, links them into services’, but the real achievements come when people leave those professional services and become independent. ‘That’s where the peer-led recovery community comes in – the best system needs both of them talking together. They are two separate worlds, and they have to be, but we need to work together to get a recovery-orientated system where people can see the way out when they come in. That’s the key.’

In terms of people becoming independent, one part of the role is to support effective joint working between treatment, housing, criminal justice, local councils and other agencies. Has this been falling short? ‘I think it probably has – not through want of trying but it’s quite a difficult thing to do, and this role is very much set up to address that. I report to the home secretary’s drug strategy board which brings the ministers from the key agencies together, so I’ve got a platform to talk about what needs to be done to improve that.’

One early goal is to speak to as many people as possible and get a view of where this is working well. ‘Obviously you’ve got areas where it does and others where it doesn’t, for a variety of reasons, but I think if we can develop a series of models that work then different areas can choose from those. That’s perhaps a more effective way of doing it.’ One crucial element is the interface between substance treatment and mental health services, he says. ‘We definitely need a more joined-up approach there.’

## There was a lot of energy five or six years ago, so maybe it’s my job to go in and make some noise and bring it up the agenda again

When it comes to working closely with ministers, there’s a fair amount of political upheaval at the moment, to say the least. There’s going to be a new prime minister, possibly a general election, and there’s Brexit. How is all this going to affect the role? ‘Who knows? It’s all been so unpredictable, so I’ve had the same thoughts. But in my early interface with the Home Office I’m quite impressed. There is a drug strategy, and it has some really good stuff in it – it’s still committed to evidence-based treatment and trying to integrate these different parts, and to helping people recover in their communities. I think all we can do is take that and keep plugging away.’

It could be that now is the time that this role is really needed, he says. ‘There wasn’t a voice in the government, and if there isn’t a voice then other issues will happily take over. There was a lot of energy five or six years ago, so maybe it’s my job to go in and make some noise and bring it up the agenda again.’

The service user voice is also something that hasn’t been heard enough, he believes. ‘I don’t think it ever is. One of the problems in our field is that if you say “service user”, it depends what you mean by the service. With users of professional services, particularly drug users, I think there’s always been a slight fear of, “if I speak out, I’ll lose the service”, which is a problem.

‘The abstinence-based recovery group is very articulate, and that voice definitely needs to be heard more, but we need both. The user voice needs to be there in policy, but it also needs to be there in treatment services. I do think service users need more say in what treatment they’re getting, and the types of treatments available to them.’

While stigma remains the ‘overarching’ challenge, there are clearly a host of others facing the sector, not least funding. ‘I think one of the worries is the public health grant and the potential loss of the ring-fenced money,’ he says. ‘A lot of money’s gone out of the sector in recent years and we have to make sure that doesn’t continue. Going hand in hand with that is the loss of skill and experience and I’d be quite keen to look at that. My particular area is psychological/psychosocial treatments, and I think that’s the bit that’s suffered and needs a voice to articulate.’

Training pathways to becoming an addition specialist via medical schools are also under threat, which could mean ‘no one articulating that this is an issue and that we can help people move on’ he says. ‘That’s all part of that stigma question – if you aren’t taught about it as a doctor or nurse or in social worker training then you form certain views which perhaps aren’t the most helpful. There’s a lot to do, but there’s also a lot of positive things going on. In some ways that’s the quick win – to put a bit of wind behind the sails of some of the really good projects, look at what we can learn and try to make sure that’s available across the country, rather than just in certain areas.’

So when it comes to the thorny issue of stigma, what’s the answer – is it simply about raising awareness and setting out to educate people like employers and housing providers? ‘Very much – that’s one part of it,’ he says. ‘I’m very impressed when you get people in recovery who can demonstrate that, despite those barriers, they’ve got to where they are. I never cease to be amazed by how often people in HR departments in big companies or wherever have never even considered that. They just automatically assume that if you’ve had a drug problem you must be bad.’ When instead they could be thinking, ‘this is exactly the sort of person we should be looking for – someone with that sort of determination and commitment’? ‘Precisely. You’ve been through this incredible struggle and you’ve come through the other side.

## Going to AA or NA meetings and hearing people talk, you can’t fail to be impressed by the power of those stories

You can appreciate what you’ve got in finding recovery, but also you’ve seen a lot of life and the difficulties people face. Going to AA or NA meetings and hearing people talk, you can’t fail to be impressed by the power of those stories. The trouble is they’re still too few and far between. We need to get that message out there, because it does change people’s minds. Many of the people we’ve cast to one side would make fantastic employees and could achieve great things. We need to keep articulating that.’ **DDN**

# STAYING AHEAD

Changes from CQC have felt demanding. Let's see inspections as an opportunity, says **Jay Stewart**

**LAST YEAR, THE CARE QUALITY COMMISSION (CQC) BEGAN RATING SUBSTANCE MISUSE SERVICES PUBLICLY**. The sector is no stranger to inspections, but publishing results means there's greater transparency of services delivered. The good news is that the sector is performing relatively well so far, with many receiving good or outstanding ratings.

Inspections have been the norm for quite a long time now, but years ago our experience of them was inconsistent in terms of their depth, breadth and quality standards.

Over recent years we've seen CQC changing. It's very welcome that there's now a framework guiding what 'good' looks like, and there are specialist advisers and experts by experience taking part in the inspection process. Equally, we've seen an increase in knowledge and experience among inspectors as they have examined services across the country.

I appreciate that this is not a view shared by everyone in the sector. As with any human system, you can have variations in judgements and in application of the regulations, but one cannot deny that the robustness and transparency of the inspection process is improving.

I've been involved in the health and social care sector for more than 30 years, so I know that it's not easy to receive an inspection that points out inadequacies in a service. Indeed, it can be a painful blow for the staff and peer mentors who give their all to help support people through recovery. However, we exist to deliver quality services and I know that we all strive to ensure that they are the best they can be.

At Turning Point we've spent years investing in our clinical expertise, governance processes and support systems, as well as in our leadership team. All of this is essential to ensuring that quality services are delivered and that learning processes are embedded into the fabric of our systems.

I know that the CQC can be minimised by some who do not want to accept that the services they are responsible for need to improve. In addition, I've no doubt that there may be occasions when the CQC gets it wrong. But we would do better to focus on what we can learn from inspections and what we can improve.

For me, one of the hallmark principles of good clinical governance and practice is being open to learning and continuous improvement. CQC inspections are much more than meeting basic regulations. Anyone who has experienced a comprehensive inspection will appreciate the depth of inquiry that happens in many inspection scenarios. As such, I think the sector has much to gain from each other through CQC inspections if we maintain an open approach to learning.

There are still many more services to inspect and no doubt areas for improvement. However, the sector should be proud of the results so far, which are quite remarkable given the fiscal pressure that we've been under. I think it stands as a testament to the value we place on quality within services.

I'd agree with those who say that quality does come with a cost. But I would also say that not providing quality services would come with an even greater cost – to a council's reputation, to real sustainable outcomes and, more importantly, to the individuals who we all seek to support in their recovery.

The new published reports give an opportunity to ensure that quality standards and investment are maintained. We should continue to challenge the imperfections in the system and do as we have always done – to strive to improve, learn and be the best we can be.

**Jay Stewart is director of public health and substance misuse at Turning Point**

# THE PLACE TO GROW

FDAP has been refurbished and offers much in the way of professional support, says **Kate Halliday**

**WHEN THE FEDERATION OF DRUG AND ALCOHOL PROFESSIONALS (FDAP) WAS TAKEN OVER BY SMMGP IN 2017** we worked hard to ensure a smooth and immediate transition for all FDAP members, and this meant continuing the existing systems of membership and registration.

Moving is chaos and once the dust had settled we were able to see what needed refurbishing. The process of registration for FDAP members was 'old school' in that a form had to be downloaded, printed, completed, and posted, together with a cheque.

The SMMGP website was also being renewed so it made sense to bring the FDAP information into a new combined website, launched in January 2019. FDAP membership applications – including payment – can now all be done online, contributing to a big jump in membership this year.

## Why become a FDAP member?

FDAP is the only professional registration body for drug and alcohol workers and now that it's under the SMMGP umbrella, there is access to expert guidance and high quality CPD via the SMMGP Premium Membership programme – all included in the FDAP membership fee.

With affiliation to several universities that offer addiction graduate courses such as London South Bank University, Bath and University of West London, FDAP's assessment board is drawn from senior lecturers and course leaders. We offer affiliate membership to providers, with benefits to nominated employees, and all FDAP members benefit from discounts on conferences and access to training.

FDAP is the only professional registration body for drug and alcohol workers

FDAP offers a range of specialist accreditation. The National Counsellor Accreditation Certificate (NCAC) is for counsellors who work with people who are using alcohol and other drugs problematically, as well as other behavioural addictions; the Drug and Alcohol Professional Certificate provides a competence-based certification for alcohol and drug workers, including volunteers; while the Drug and Alcohol Family Worker certificate (with Adfam) is designed for practitioners who work with families affected by addiction.

We are proud of the strides that we have made to upgrade FDAP and keep our members happy. The professional body was established, and continues, to uphold standards of competency and professionalism specific to our sector. We invite you to visit our new website and browse what's on offer: www.smmgp-fdap.org.uk

**Kate Halliday is SMMGP/FDAP executive director**

More workforce development at:
www.drinkanddrugsnews.com

Making sure our clients have the right skill sets for the workplace is vital to their social mobility, says **Asi Panditharatna**

# KEEPING CLIENTS MOVING

**THE RECENTLY PUBLISHED REPORT *SOCIAL MOBILITY IN GREAT BRITAIN – STATE OF THE NATION 2018-19*** has highlighted a number of concerns for those from disadvantaged backgrounds. We believe this applies to many of the clients we support who are in substance misuse recovery – particularly those from low-skilled, unemployed, NEET (not in education, employment or training) backgrounds.

The report confirms that people in low paid roles tend to get stuck there and are more likely to be from lower socio-economic backgrounds. Connected to this, those with the least skills are unlikely to get training and higher or degree level apprenticeships. This is against a backdrop of two-thirds of the reported growth in UK employment (with around 75 per cent of people aged 16-64 now in work) having been in 'atypical' roles such as zero-hours contracts or agency work that do not provide job satisfaction, security or contractual rights. Such roles can make it hard to plan for the longer term, such as obtaining a mortgage.

The report also highlights that those with fewer skills are the least likely to get the training they need to support their progression in the workplace. The new apprenticeship standards led by employers have the potential to be a powerful vehicle for social mobility, but the reality is not as clear cut; those from lower socio-economic backgrounds are clustered in lower-returning and lower-level apprenticeships and are not benefiting as much as their more affluent peers.

As automation changes the world of work, these divides could worsen – workers in low-paid roles with low qualifications are most at risk of their work being automated but least likely to access training to reskill.

This may seem like a bleak outlook, but the solution lies in establishing a firmer foundation for the future – access to skills, training and job opportunities with a clear career trajectory.

At The Forward Trust, our approaches to achieving this include focusing on promoting talent with employers so they are not just looking at managing risks with people in recovery. We also make sure employability and vocational training support is aimed at people having maths, English (contextualised for work) and the digital skills to find a job and then succeed in their role.

The solution also includes helping clients to access higher-level government apprenticeships that offer progression and promotion routes. We are focusing on progressing people into higher level qualifications, for example our new ESFA ESF contracts are training people in customer service diploma level qualifications, so they can access higher paid roles in the digital sector in London.


As younger people from disadvantaged backgrounds do not necessarily have the support networks to give them a leg-up in their career, another component for success is giving them access to a network of peer support – so that clients, learners and service users can also draw on one another for help, as well as tapping into each other's networks for jobs.

In essence, it's about creating a range of different pathways for people to access better-paid employment – including jobs, apprenticeships, traineeships, self-employment and setting up a business/social enterprise – as well as the support networks to bolster this and ultimately drive social mobility.

To celebrate Employability Day on 28 June, we are planning an employers' roundtable to discuss these issues around talent and progression. For more information about Forward Trust's employment services, see www.forwardtrust.org.uk/our-services/employment-services/

**Asi Panditharatna is divisional director of employment services at The Forward Trust**

As automation changes the world of work... divides could worsen – workers in low-paid roles with low qualifications are most at risk of their work being automated but least likely to access training to reskill.

# INNER STRE

Emotional intelligence can be a potent tool for recovery, says **Derek Fredericks**

One hot summer's day 13 years ago, I remember sitting alone on the 192 bus to Stockport. Clutching a satchel to my chest, my thoughts swirling, I was struggling to breathe. I caught one of the thoughts: 'They are not going to like you.' Then another: 'You're going to fail', coming at me like blows from a heavyweight boxer. I felt hopeless.

It had been a tough six months – no drugs, no alcohol, no release and no escape. I thought about the 20 years of drugs, crime and prison, and now at 38 years old I was going to college to sit in class with 'normal people', to study Health and Social Care Level 1. What did that even mean?

As the bus stopped, I spotted three men huddled together, talking excitedly. I looked closer and realised I knew them all and had used drugs with them. As a BMW stopped, they all ran towards it. 'THEY'RE SCORING!' Standing up with a start, I thought: 'God!

# ENGTH

'My first recollection of a drug fixing my feelings was when I was nine years old. It was the morning after I was taken from the family home and put into a care home.'

That looks attractive.' No sooner had I had the thought and sat back down, I began to question it. What's attractive about sitting in a crack house? What's attractive about prison? What's attractive about not seeing my sons?

This was one of the pivotal moments in my life, when unwanted and intrusive thoughts could have changed not just my own destiny, but that of my sons and countless other people. This was when I started to become aware of my thoughts. I didn't know it at the time, but this was the beginning of the development of my emotional intelligence; the beginning of my empowerment – of learning to use a dormant skill that I wasn't even aware existed.

I stayed on the bus and I passed the course, and the next, and the next. I began to question negative thoughts and emotions and started to practise not succumbing to them.

## WHAT IS EMOTIONAL INTELLIGENCE?

Emotional intelligence (known as EI or EQ) is a term created by two researchers – Peter Salovey and John Mayer – and popularised by Daniel Goleman in his book *Working with Emotional Intelligence*. It refers to the ability to identify and manage one's own thoughts and emotions, as well as those of others. Goleman cites the Harvard Business School research that determined that EQ (emotional quotient) counts for twice as much as IQ (intelligence quotient) and technical skills combined, in determining who will be successful.

Being addicted to any substance indicates a person's refusal or inability to process thoughts and emotions, especially when the consequences become severe and the person finds it difficult to halt the process of 'fixing feelings'. As time goes on, it becomes more difficult to identify and manage emotions.

My first recollection of a drug fixing my feelings was when I was nine years old. It was the morning after I was taken from the family home and put into a care home. I was distraught at being taken away from my family, and I screamed the place down. I remember waking up the next morning, hearing birds singing and being very calm. It was almost as if the trauma of being taken away had vanished overnight. I found out years later that I was given diazepam to calm me down – my first experience of my emotions being 'fixed'. A pattern was set; I then knew, subconsciously, that I didn't have to experience uncomfortable emotions.

We are told we are addicted to whichever drug we are taking when, in reality, we are addicted to not feeling – we just choose different vehicles to get to the same place. I had a lot to relearn. I had to recognise the difference between a feeling and a thought. We have all heard people say 'I feel like a pint' or 'I feel like a failure'. These are not feelings – these are thoughts. When I work with clients or students, this is one of the first things I ask them to investigate.

When I started using drugs in the 1980s, the only help that seemed to be available was Nancy Reagan's advice, 'Just say NO!' Very good, Nancy, but how do I do that? Although simple in theory, recovering from addiction or from unprocessed emotions is fraught with obstacles, dangers and, mostly, the negative 'self' that will try to take us back to misusing substances again. We need to become aware of our emotions and thoughts, so we can better accept and challenge them. We need defences and protection. This is why I think enhanced emotional intelligence is essential for successful recovery.

## CAN WE TEACH IT?

I am frequently asked the question, 'can you teach emotional intelligence?' and the simple answer is no. However, what we can do is make each other aware of the barriers that stop it developing naturally. There are proven ways to help this, such as the 'Johari window' – a simple tool to help with self-awareness.

Maslow's Hierarchy of Needs also helps with experiencing self-actualisation. It's funny how I thought a speck of powder could destroy my life, when in fact the risk was from unmet basic needs – lack of connection, poor self-esteem and, most of all, not enough experience of triumphs. Emotional intelligence can help develop skills relating to assertiveness, maintaining safe boundaries, developing and enriching relationships, dealing with change, taking calculated risks, and many other areas of personal growth.

In a lot of ways, I am just as scared as I was back then. My esteem can still be low, but the difference now is that, through an awareness of my thoughts and feelings, I am able to challenge my emotional and mental state and not give it power. With fearful situations, I do it anyway – at least sometimes.

For eight years, I worked with people who were still using drugs in a group setting and, each day, the objective was always to enhance their emotional intelligence, empowering them to have more choices. Today, I teach counselling and addiction awareness to people in recovery, as well as teenage schoolchildren, corporate managers, nurses, perpetrators of domestic violence, addiction workers, therapists and anyone who wants to be the best they can be. At the Calico Group, where I work, our chief executive Anthony Duerden ensures that training around emotional intelligence is delivered across the organisation.

As therapeutic workers striving to help the wounded, I am convinced that we become more potent at what we do when we ourselves strive to enhance our own emotional intelligence.

**Derek Fredericks is academy manager at Acorn Recovery Projects, www.acornrecovery.org.uk**

## KARL'S JOURNEY

### Learning about emotional intelligence gave Karl the techniques to begin living life the way he wanted to

Karl had been addicted to heroin since the age of 17 and came into treatment aged 34. He was homeless, with destructive behaviours and a chaotic lifestyle. He had contracted hepatitis C and had turned to crime to support his drug habit. He was also selling himself.

These behaviours went against all his morals, beliefs and values. He had attempted suicide numerous times. His mother had committed suicide while he was in addiction. Karl thought he was 'worthless and better off dead'.

Through a therapeutic process Karl was able to look closely at his thoughts, behaviours, and actions in a safe environment. He was able to improve his self-awareness through enhancing his emotional intelligence. With this process came the development of certain key skills to move on with his life. Karl reported that since putting down the drugs it had all become about living his life. This meant managing himself, his thoughts, emotions and relationships. He began to manage his emotional state by being aware of his negative self-talk, and with this awareness he began to challenge himself to go further. His self-control was improving and through the techniques of emotional intelligence he began to get experience of achieving.

His relationships also began to improve, which he felt was a massive part of his recovery. He began to form boundaries and become more assertive, allowing his relationships to flourish, and he began to get in touch with his natural empathy for others.

Karl is now helping other people develop and enhance their emotional intelligence through his work as a tutor and counsellor.

**The strength of evidence demands a clear strategy to overturn failing drug policy, according to a meeting of parliamentarians, police and policymakers**

# RISING TIDE

The 'tough on drugs' approach is impractical, outdated and costly in every sense, according to a meeting of the APPG for Drug Policy Reform. Considering pieces of evidence from home and abroad – including Germany, Portugal and the Czech Republic, where legislation had decriminalised drug consumption – the group discussed how the lack of a clear national strategy was resulting in inconsistent law enforcement relating to drug possession and consumption in the UK.

A decade ago we were familiar with arrest referral schemes and their successor, the Drug Interventions Programme. This government-funded programme was used in courts and custody suites to divert people who had been arrested in possession of drugs into education and treatment programmes, rather than prison. With funding withdrawn, drug-related crime rates were rising as fewer offenders with drug problems were being referred into treatment.

Furthermore, the group was concerned at the 'postcode lottery' playing out – in some areas people might receive a warning or a fine; in other areas they would receive a short prison sentence for the same offence. Those on the receiving end of harsher punishment, it was noted, were more likely to be from poor areas and minority ethnic groups.

Mike Trace, ex deputy drug czar to the Blair government, said that in the UK we used to be very enthusiastic about diverting people into treatment, but that this had declined over the last ten years. However, he believed the Ministry of Justice was now interested in diversion and deflection as it was cost effective.

Some police and crime commissioners were running early stage deflection schemes, referring people into education and treatment programmes. Among them, chief inspector Jason Kew had become increasingly convinced of the value of this approach in the Thames Valley. 'We have had nothing but private engagement and support and acknowledgement that we need to reform,' he said. Pre-arrest diversion was 'as close to decriminalisation as you can get in the current framework', but it was a postcode lottery. Two miles down the road you could end up in custody.

'If we were using decriminalisation [a system like in Portugal] we wouldn't need to be talking about diversion,' he said, adding 'We are trying to evolve and innovate, but are also having to deal with the effects of austerity on drug services.'

Despite the constraints of the current legislative framework, there had been an opportunity to give evidence to the Home Office independent review of drug markets and violence, led by Dame Carol Black. The National Police Council were contributing, said Kew, and Kirstie Douse added that Release were submitting a full response. The review would be looking at drug harms – an opportunity, the meeting agreed, to provide strong evidence on harm reduction that should pave the

> 'The lack of a clear national strategy is resulting in inconsistent law enforcement relating to drug possession and consumption in the UK.'

# BORDER INTELLIGENCE

## The Drugs, Alcohol and Justice Cross-Party Parliamentary Group also met in May to discuss what England could learn from drug and alcohol strategies in Scotland and Wales

way for legalisation. Evidence would include detail and working practice – such as in Switzerland – on heroin assisted treatment (HAT) and drug consumption rooms (DCRs).

While evidence was being collated and debated there was an urgent need to engage now with people about their drug use, as Fiona Measham explained. Her service, The Loop, had been bringing a mobile drug testing service to outdoor events, with a great deal of positive engagement – from local police as well as festival-goers. It's a model that has become a much-valued part of the festival scene – 'one in five people hand over their drugs when they find it's not what they expected,' she said.

But there was now a major obstacle to operating the service: the Home Office had announced they would be licensing mobile testing (previously 'a bit of a grey area', as there wasn't a licence that fitted a mobile lab situation). The application would take at least 12 weeks, meaning The Loop was 'on hold' until then.

'So the concern is, we're moving into the summer season and have had to cancel presence at imminent events,' said Measham. 'We're all in limbo waiting for the licence, but don't want to endanger the support of the Home Office long term.'

Members of the APPG hoped there would be a way around this. 'We can't let bureaucracy make this a lost summer,' said Trace. DDN

A new strategy for Scotland, *Rights, respect and recovery* had the aspiration of putting recovery at its centre, said Andrew Horne, director of Addaction Scotland and an advisor to the Scottish government for the last 14 years.

There were now at least 120 organic self-starter recovery groups, which were 'about people taking back their own recovery and not led by services'.

Scotland had 60,000 dependent drug users and a predicted 1,000+ drug-related deaths in 2018 – three times the rate in England. There had been recent rises in HIV and hepatitis C, in both the chemsex and mainstream using community. Horne mentioned the 'Glasgow effect' – the drop in life expectancy by seven years for residents, irrespective of their social group, age or ethnicity.

The news was that there had been a mind shift, said Horne. Scotland was now treating substance misuse as a health and social issue – a health issue first, rather than a criminal justice issue. 'People have the right to be safe and well,' he said.

There was a 'big need to address stigma' in personal and media references. 'Stigma stops people from entering treatment,' he said. Service users were still a very disempowered group that needed more advocacy to help challenge decisions about their treatment. Scotland still had health boards, 'which can be clinical and consumer led and seen to lack compassionate care', he explained, and it was important to listen to what peer-led groups had to say.

Drug treatment in Wales was health led and there was an holistic approach, but it could get lost in the 'huge portfolio' of devolved responsibility, said Caroline Phipps, CEO of Barod, a third sector organisation for adults and young people.

It was an interesting time, she explained, as Wales was coming to the end of a ten-year strategy that had started to see a reduction in harms. The strategy review was showing evidence of short-term impact and the value of a harm reduction approach, but intelligence was missing on longer-term impact and whole-population intervention.

One of the main concerns was that those with the most complex needs were being failed, often because of stigma. 'We need to review concerns around OST, waiting times and access to services,' she said, as well as looking at some of the criticism being levelled at commissioners and services.

> 'There has been a mind shift. Scotland is now treating substance misuse as a health and social issue.'

'People die of stigma – it's the biggest issue,' she said. *Well-being of Wales* gave a policy framework that needed to ensure service user voices were heard.

An ageing population, strong drugs, lack of funding and a spike in drug-related deaths gave the 'most challenging conditions of the last 20 years', underpinned by county lines, alcohol-related harms, hepatitis C rates, poverty and isolation.

In positive news, there was a ten per cent increase in funding for the sector in Wales, with a focus on harm reduction, protecting families and reducing drug-related deaths. There were good projects on distributing naloxone, said Phipps, as well as effective service user involvement and a pragmatic approach to patient choice. There was now a need to be 'brave and bold' with DCRs, diversion schemes and decriminalisation. DDN

# REJUVENATING THE SECTOR

How do we harness political support when priorities lie elsewhere? In the sixth of his series of articles, former deputy drug czar **Mike Trace** sizes up the challenge

Twenty years ago, the Labour government positioned substance misuse treatment as one of its key social policy priorities and increased central government investment by more than 400 per cent. These were the golden days of political support, but we are now in a period of central government indifference, linked to significant budget reductions.

When the NTA closed down, I remember Paul Hayes and Department of Health officials urging the sector to work hard to convince ministers, local councillors, and directors of public health of the financial and policy merits of substance misuse treatment. This was reasonable advice, as it was clear that we were leaving a period when policy support and generous budgets were assured, and our sector would have to compete with more mainstream concerns, within the context of a local government financial squeeze.

But it was also a bit of a cop out – the big decisions that affect the level of focus and investment in the sector had already been made: the closure of the cross-government agency set up to act as a custodian; the end of the central government drug treatment 'pooled budget'; the incorporation of that money into a wider local authority public health grant; and the removal of the ring fence on that grant. The period since those decisions were made has seen politicians at local and national level talk widely about the value of substance misuse treatment, but no serious attempts to reverse the decline in resources or develop new or expanded services.

So what 'big wins' can the sector offer to policy makers to rejuvenate the sector? Unfortunately, not all of the benefits we see from the treatment system can be translated into political support and increased budgets.

**SUBSTANCE MISUSE TREATMENT REDUCES BLOOD BORNE INFECTIONS?** The fear of drug-related HIV and hepatitis infections has receded as transmission rates have declined and treatments have improved. The cost/benefit analysis of public health prevention measures remains positive, but there is no sense of the crisis that is needed to stimulate policy action.

**SUBSTANCE MISUSE TREATMENT REDUCES DRUG-RELATED DEATHS?** The shocking level of drug-related deaths has also not been enough to trigger a significant reaction. It seems true that drug users' lives are seen as less important – if we had more than 3,000 early deaths per year due to traffic accidents or knife crime, we would be witnessing national campaigns and bold new investments. We also have a problem in claiming treatment can significantly reduce deaths. Policy makers will ask why the death rates have gone up throughout the period when the number of people in treatment expanded massively.

**SUBSTANCE MISUSE TREATMENT REDUCES CRIME?** This was the argument that most interested ministers when I was in government. And the theory was largely proved correct, with the types of crime most associated with dependent drug use declining significantly between 2000 and 2010. Whether it holds the same potency now – when volume crime rates are lower, and enforcement priorities are moving more towards violence reduction and organised crime – is questionable, but the financial case remains compelling; treatment reduces offending, which in turn significantly reduces criminal justice expenditure.

**SUBSTANCE MISUSE TREATMENT REDUCES SOCIAL EXCLUSION?** This has in my view always been the sector's trump card. Our sector deals with a high proportion of the most socially marginalised individuals. They experience, and cause, multiple problems beyond drug and alcohol dependence. If our interventions can reduce those problems – homelessness, family break-up, unemployment, low-level mental health problems – then it is meeting the objectives of many central government departments. Unfortunately, we have not been very good at demonstrating our impact in these areas – research has been patchy, and our commissioning data sets do not provide sufficiently clear results.

**SUBSTANCE MISUSE TREATMENT REDUCES HEALTH SERVICE UTILISATION?** This seems plausible, and there is some research to show reductions in, for example, A&E presentations, GP appointments, or liver failure. But we still do not have any comprehensive data on the impact we have on our clients' use, and costs of other NHS services. I would imagine that such research would demonstrate a strong case for substance misuse treatment as a cost-effective prevention measure within NHS strategic plans.

There is a pathway to re-energising political support for our sector, but I fear that we have not been making the right arguments, or assembling and presenting the right evidence. The scramble for resources in a time of austerity is brutal but inevitable – to protect existing budgets, or gain support for new developments, the substance misuse treatment sector needs to offer big gains in a policy area that the politicians and public care about.

While our public health achievements are worthy of celebration, they will never rise to the top of local authority or NHS priorities. It is more likely that rejuvenated interest will come from the social inclusion agenda – helping people to move from positions of deprivation and dysfunction into work, stable accommodation, and positive connections with family and community. And while it is true that the current national government is not at all focused on social inclusion, it will not be in power much longer.

Local governments will always see the benefits of moving people into jobs, and helping them off homelessness or social service registers. We need to offer them a clear, and evidence based, vision of what can be achieved. The long overdue appointment of the government recovery champion – Dr Edward Day – presents an opportunity to articulate this vision at the highest levels. My next article will contain some suggestions for how he can go about this task.

**Mike Trace is CEO of Forward Trust**

**DDN WELCOMES YOUR LETTERS**. Please email the editor, 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.

## APPALLING OVERSIGHT

Thank you for publishing the article 'System Failure' about the lack of support for people who've experienced childhood sexual abuse (*DDN*, May, page 10). While I'm glad that this issue is finally getting some attention, the fact that it seems never to have been properly addressed in most services is an astonishing oversight. I was also shocked to learn that there's not even a system in place to collect this sort of data in the first place.

The article quotes Chip Somers saying, 'We all know the numbers are immense, yet this is an issue which still gets sidelined.' I can attest to this, having raised the subject more than once in my previous job only to essentially get fobbed off. It seems a wasted opportunity of immense proportions, particularly at a time when funding is becoming ever more scarce.

If someone has an entrenched drug or alcohol problem because they're self-medicating to numb the pain of an underlying issue as serious as this, what on earth is the point of not properly addressing that issue or not referring them on to qualified, professional help? They'll finish treatment, relapse sooner or later, and be right back where they started. It's essentially the equivalent of giving a cancer patient some heavy painkillers but no treatment for the condition itself.

The need for 'better joined up working' has become a mantra in this field, as it has in many others, and we all know it's often just something to say. But all services should have an effective process in place for referring the people who need it to specialist support, as they should when it comes to the – clearly not unconnected – area of mental health. Otherwise we're letting our clients down appallingly, and basically just wasting our time.

*Name and address supplied*

## AWKWARD FACTS

**Your 'Media Savvy' section very often features national newspaper columnists opining that the 'war on the drugs' has been lost and the only sensible solution is legalisation and regulation. This is now pretty much mainstream thought in broadsheet newspapers across the political spectrum, the most recent example being Christine Jardine of the *Independent* (*DDN*, May, page 13). Young people are 'pushed towards dealers, and dangerous unregulated backstreet drugs', she tells us. Would the drugs be less dangerous if they were bought on a main road then?**

***Vice* also had a handy article a few days ago called 'How to legalise every drug'. Here, Steve Rolles of Transform pops up to tell us that for cocaine, for example, a 'licensed user pharmacy' model would be the best option. People would have to pass an assessment to buy a 'rationed amount – say a gram a week', and the price would also need to be kept high enough to 'avoid encouraging use'.**

**Am I missing something here? If you have any kind of a cocaine problem then a gram a week isn't going to be anywhere near enough, so you'll be straight back round to your dealer. Ditto if he can offer a better price, which he will – obviously. So how is this going to take the market out of the hands of dealers and criminals?**

**And wait, I thought part of the argument about legalising and regulating drugs – especially heroin – was that people wouldn't then be driven to acquisitive crime to fund their habit because the prices were too high? So the price needs to be high enough to discourage use, but not so high that they encourage crime? How much, then? To add to the confusion, it's often the same people calling for legalisation who also want to see minimum pricing introduced for alcohol to discourage harmful use, because the prices for that are too low. One can only wonder how they manage to square that particular circle in their heads.**

**The elephant in the room is of course the US, where the overdose rate quadrupled in the first 15 years of this century as, coincidentally, did opioid prescribing levels. That's half a million people dead, a lot of it from legal, regulated drugs. And then there's mephedrone. Before it was banned it had very high rates of use among students and other young people who'd never taken drugs before but thought this was OK because it was a 'legal high'. When it was made illegal, rates of use fell off a cliff. But those sort of facts are a bit awkward, aren't they? So let's just ignore them.**

*Molly Cochrane, by email*

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# A CALL TO ENGAGE

Action on Addiction's chief executive **Graham Beech** introduces a new Addiction Awareness Week on 10-16 June

### WHERE DID THE IDEA COME FROM?

Everyone knows the problems associated with addiction are growing and becoming increasingly complex. At the same time, society's capacity to deal with these issues is diminishing. People are finding it increasingly difficult to access the treatment they need and are facing sizeable barriers linked to stigma.

We're hoping Addiction Awareness Week will play a key role in raising awareness of the far-reaching negative effects of addiction and providing a platform for focused conversations about the wide-ranging benefits of community-led recovery. We're also looking to share inspirational stories so that people feel inspired to seek the help they need, and more is done to help them achieve a rewarding and stable life in recovery.

### WHAT WILL HAPPEN?

The week is a great opportunity to put the spotlight on addiction and for people to connect and to challenge stigma and discrimination. The conversations which will take place, in Westminster and Whitehall, in cafés and bars, and around people's kitchen tables, will help bring addiction out of the shadows and in front of the public eye.

In addition to organising our own events throughout the week, we'll be working with charities and other organisations who have timetabled their own initiatives and social media activity. The idea is that by working together during a week focused on addiction, we'll be able to cut through the news agenda and engage many different audiences.

### HOW WILL IT SUPPORT OTHER INITIATIVES?

There are already a number of fantastic campaigns and initiatives that challenge stigma and increase knowledge about addiction, in many of which Action on Addiction participates. An awareness week that focuses on the subject and becomes an annual event should add significant weight to these activities. Substantial headway has been made in recent years on raising awareness of issues associated with mental health, and we're hoping for a similar shift in relation to addiction. Changing hearts and minds can never be achieved through one campaign in isolation, it always requires a groundswell of activity from multiple organisations who are able to engage clients and service users, ambassadors, donors, and high-profile supporters.

### HOW DO PEOPLE GET INVOLVED?

We've received an overwhelmingly positive response throughout the sector. The week is also being supported by those operating in related services and arts organisations, from MPs, policy professionals and in the media. We'd love people to share their stories throughout the week on social media and via their own communications channels. Our email address is: hello@addictionawarenessweek.org.uk

*For more information visit www.addictionawarenessweek.org.uk*