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THE EXPERIENCE

Newsletter of The UK Drug Workers Forum

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Date for your Diary:

UKDWF ANNUAL NATIONAL CONFERENCE 2009

13-14 October 2009 York

2009 - NEW OPPORTUNITIES AND CHALLENGES FOR US ALL …….

Hi All,

Hope you all had a Merry Christmas and can look forward to a prosperous and successful 2009.

Settling back into the daily grind, thoughts turn to the new year ahead and the changes, opportunities and challenges it may bring. The buzz at the moment is around the 'Welfare to Work Agenda' and how this will affect agencies in meeting its aims and objectives when implemented later this year. The UKDWF will include discussion around this topic at its regional forums and is also in the process of investigating and collating information on current practice and training needs to meet the inevitable changes ahead. A questionnaire is included in this Newsletter and we would appreciate your feedback on this topic.

Also in this issue, is our planned schedule of regional events. We hope to see members old and new at these important regional gatherings which provide you with the opportunity to question policy, raise issues of concern and share best practice with colleagues in your region.

The 2009 Annual Conference will again be held in York. The dates are **13-14 October.** Based on feedback from previous events and current economic climate, participants at this year's conference will see some significant changes in the format which will be designed to enable individuals to tailor their own conference experience …….. watch this space.

News from the UKDWF Board:

- John Hopkins has regrettably resigned from the Forum Board due to his promotion to Managing Director of Acorn House. His support over the past 12 months has been much appreciated and we wish him well in his new role.
- We welcome Nigel Atkin to the Forum Board. Nigel was one of the founder members of the Forum and brings much expertise as well as drive and enthusiasm to our work.

We look forward to seeing you at the regional events over the next 12 months.

Best regards,

The UKDWF Management Team

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Toxic Bacterial Skin Infection Claims Lives of Two Injecting Drug-Users

TWO injecting drug users have died following an outbreak of ***necrotising fasciitis*** among injecting drug users in the West of Scotland, it has been confirmed. However, a third victim along with a fourth possible case, are still being treated in hospital and are making a gradual improvement. No new cases have yet emerged. The deaths took place on 24 December and 3 January and the outbreak prompted NHS Lanarkshire to issue a public health warning on 29 December urging injecting drug users not to inject heroin.

Dr John Logan, Consultant in Public Health Medicine at NHS Lanarkshire said:

"The patients affected may have injected heroin that was contaminated with spores that can cause severe illness.

"We would advise drug users not to inject heroin and warn that muscle-popping, skin-popping, and injecting when a vein has been missed, are particularly dangerous. Smoking heroin carries much less risk than injecting it. If there is any pain or swelling around an injection site drug users should seek urgent medical attention."

Drug agencies, pharmacists, general practitioners and Accident and Emergency departments have been advised to be on alert for possible signs and symptoms to ensure early access to treatment.

Dr Logan said the clinical picture of the cases was similar to that seen in and around Glasgow in 2000. A similar outbreak that year claimed the lives of 43 injecting drug users over six months in Scotland, north-west England, the West Midlands and Dublin. A fatal accident inquiry found 16 people from the Glasgow area contracted the Clostridium Novyi bug from a contaminated batch of heroin.

NHS Lanarkshire advice for drug users:

- Don't use heroin
- If you have to use heroin, smoke it instead of injecting. (Muscle-popping, skin-popping and missing the vein are particularly dangerous)
- Don't share needles, syringes, cookers/spoons or other 'works' with other drug users
- Use clean works for each injection (don't re-use needles)
- Cleanliness is important: prepare in a clean place and carefully wash hands and skin first;

If there is swelling, redness, or pain where someone has been injecting, or pus collects under the skin, go to a doctor to check it out immediately, especially if the infection seems different to others experienced in the past.

Source: Scottish Drugs Forum

Necrotising fasciitis (flesh eating bacteria) – The Facts

Necrotising fasciitis is a rare bacterial infection that can destroy skin and the soft tissues beneath it, including fat and the tissue covering the muscles (fascia). Because these tissues often die rapidly, a person with necrotizing fasciitis is sometimes said to be infected with "flesh-eating" bacteria. The most common type of bacteria causing necrotizing fasciitis is *Streptococcus pyogenes*. When necrotizing fasciitis occurs in the area of the genitals, it is called Fournier gangrene. Necrotizing fasciitis is very rare but serious. Around 30% of those who develop necrotising fasciitis die from the disease.

Many people who get necrotizing fasciitis are in good health prior to the infection. Those at increased risk of developing the infection are people who:

- Have a weakened immune system or lack the proper antibodies to fight off the infection.
- Have chronic health problems such as diabetes, cancer, or liver or kidney disease.
- Have cuts, including surgical wounds from operations such as an episiotomy or a hernia repair.
- Recently had chickenpox or other viral infections that cause a rash.
- Use steroid medicines, which can lower the body's resistance to infection.

Ecstasy – Downgrade to Class B Drug

Advisory Council has 'pro-drug' agenda, say critics, raising questions over its fitness to advise ministers.

An independent committee that advises ministers on drug classification is poised to recommend the controversial downgrading of ecstasy to a class B drug. The Advisory Council on the Misuse of Drugs (ACMD) is expected to call for ecstasy, a drug blamed for the deaths of at least 30 people a year, to be changed from its top-rated class A category when it reports later this month.

The proposal will bring the council into direct conflict with the Home Secretary, Jacqui Smith (below), who is expected to veto any such move, and propel the Government into a row over its treatment of expert bodies charged with advising ministers on key issues. The controversy comes just months after the Home Office ignored ACMD opposition to the decision to move cannabis from class C to class B.

Senior Home Office sources said they "fully expected" the ACMD to call for the relaxation of ecstasy's classification. Professor David Nutt, chairman of the committee, which is reviewing ecstasy at the request of MPs, has suggested it is less dangerous than alcohol or tobacco, and stated that it is "probably too highly classified".

Downgrading the drug, which is popular with clubbers, to class B would reduce the maximum prison sentence for possession from seven years to five, while the maximum prison sentence for dealers would fall from life in prison to 14 years. It shares its current classification with drugs such as heroin and crack cocaine.

Anti-drug campaigners have attacked any move to downgrade ecstasy. The shadow Home Secretary, Dominic Grieve, said: "Drugs wreck lives and destroy communities. Ecstasy is a drug that is very damaging."

Critics have also called into question the ACMD's fitness to advise ministers. David Raynes, a member of the National Drug Prevention Alliance, said the ACMD should be "an impartial centre of expertise carefully weighing evidence and public good". He added: "Recent behaviour leads me to believe it is being controlled by a few ideologues, pursuing a broadly liberal and pro-drug, legalisation agenda."

Mary Brett, spokesperson for Europe Against Drugs, said: "The present ACMD includes few members who take a definite drug-prevention stance. It is imperative that a committee of this importance needs to be properly balanced."

Professor Andy Parrott, an experton ecstasy, said he was concerned that there were insufficient scientists on the committee. "It is quite an odd committee. It is not very scientific. This issue should not just be about opinions – it should be about the actual effects this drug has on people's brains and bodies. I have conducted years of research into ecstasy and I can tell them that it is not possible to take this drug without being damaged by it."

In a critical report on drugs policy in 2006, MPs on the Science and Technology Select Committee accused the ACMD of a "dereliction of duty" over its failure to alert the Home Office to serious doubts about the system's effectiveness. The MPs also expressed "surprise and disappointment" that the ACMD had never reviewed the evidence for ecstasy's class A status.

A Home Office spokeswoman said the ecstasy review was "hugely unwelcome". She added: "Ecstasy can and does kill unpredictably; there is no such thing as a 'safe dose'. The Government firmly believes that ecstasy should remain a class A drug."

Source: The Independent

Sentencing for Drug Users – A More Flexible and Effective Approach

The UK Drug Policy Commission published its report *Reducing Drug Use, Reducing Reoffending* earlier in 2008. The report looked at whether interventions within the criminal justice system (CJS) aimed at problem drug users are effective at reducing drug use and offending, and whether they offer value for money. Their three main findings were:

1. Little is known about the effectiveness of many CJS-based drug interventions, especially those in prisons, despite the considerable public expenditure.
2. Prison drug treatment provision often falls short of even minimum standards.
3. There is a risk of causing more harm than good by sending a significant and growing number of problem drug users to prison, especially for relatively short sentences.

Offending by drug users is closely linked to their drug use and often involves less serious acquisitive crimes such as shoplifting. Subsequently they are likely to experience only short spells in custody which can have a serious, negative effect on their rehabilitation through:

- loss of stable accommodation and employment;
- disruption to family relationships and other sources of personal support;
- disruption to any community drug treatment with little prospect of 'equivalence of care' in prison due to variable standards and limited treatment options;
- increased risk to health (particularly if injecting drugs) whilst in custody;
- increased risk of overdose and death upon release if tolerance has dropped (following a period of abstinence or reduced dosage); and
- temporary loss of benefits following release while new claimants are processed (having been automatically dropped from the books when entering prison).

Regardless, 80% of new receptions to prison have a history of substance abuse and between one third and one half are estimated to be current problem users.

Available evidence suggests community sentences are likely to be just as good as custodial sentences at reducing reoffending and drug use and, given the high costs of prison, they are likely to offer better value for money. However the main question is whether we can ensure that appropriate and effective alternatives to custody for those with drug problems are available, utilised, and delivered in a way that will preserve the authority of the courts. A recent Ministry of Justice study showed, there is wide regional variation in the use of custody. The effective use of community sentences could be hampered if some regions feel less willing to use them than others.

The criminal justice system could find more effective outcomes – both for the users and for society of provision and thus on outcomes. Specialist drug courts sometimes come close to resembling 'one-stop shops' for offenders with drug problems, not least because members of the judiciary can have influence over services where these are locally available. There are likely to be many benefits of a one-stop shop for substance abuse, but perhaps it would be preferable if these existed outside the courthouse and were open to offenders and non-offenders alike, with the court one of many services available, as is sometimes the case in the USA.

Fur new drug courts will shortly be added to Leeds and West London, but if this approach is rolled out nationally, the underlying principles will need to be integrated into general community sentencing practice. This will present challenges, such as the logistics involved in providing continuity of judiciary.

Evaluation of the Leeds and West London drug court pilots found that training the judiciary in, among other things, the nature of addiction was deemed essential for success. To improve outcomes, the focus must be on quality – of sentencing, services and supervision.

Full UKDPC Report: *Reducing Drug Use, Reducing Reoffending* - www.ukdpc.org.uk/reports.shtml
Full Magistrate, Winter 2008 Report available on www.ukdrugworkersforum.org

Source: Magistrate, Winter 2008

New DIP Factsheet – December 2008

HOUSING DRUG USERS

Drug users are more likely to relapse and re-offend if they become homeless. The Drug Interventions Programme (DIP) is working with a range of partners on a joined-up housing strategy to provide vulnerable users with the support they need to maintain tenancies and stay in treatment.

Lack of stable housing was cited by 40% of drug users as the main barrier to them achieving their treatment goals. Long-term drug users reported a series of tenancies lost because of their chaotic lifestyle and offending. There is currently no common structure which brings housing and drugs together at a local level to meet the varying and complex needs of drug users.

Housing is key to rehabilitation

In the chaotic life of a problem drug user, housing can often be the only stability there is. Stable accommodation can be the difference between staying in treatment and returning to crime and anti-social behaviour. In particular, evidence shows that those leaving drug treatment or custody without their housing needs being assessed and met are more likely to relapse and re-offend. Even those who are housed are likely to lose their accommodation if they do not receive the right support to sustain their tenancy.

Statistics from the Audit Commission clearly establish the link between homelessness and drug misuse.

- Three-quarters of single homeless people have a history of problematic substance misuse (rising to more than 80% of rough sleepers).
- More than 40% of single homeless people cite drug use as the main reason for homelessness, while two-thirds report increasing problem substance misuse after becoming homeless.
- Extensive research by Addaction (2005) found that 83% of substance misusers felt that stable housing was one of the most important support services required to help them stay clean.

Joined-up thinking

It is clear that stable housing can help to reduce re-offending rates and anti-social behaviour, as well as meeting drug treatment targets. It can also improve the employment prospects of the service user and reduce health inequalities.

But it is equally apparent that any housing strategy will be ineffective without a range of housing and related support services needed to sustain service users in their tenancies. These may include anything from practical help with cooking and paying bills to mental health services and life skills development. Meeting these complex needs demands a joined-up approach to service provision. Agencies responsible for preventing homelessness, delivering the drug strategy, reducing re-offending and improving health must work closely together, along with housing service providers – and users – to deliver the right level of support.

How this can work

For example, housing providers can help by planning the management of drug issues in their accommodation and bringing users into treatment. Likewise, by providing treatment at home, drug service workers can help service users maintain their housing, thus reducing the incidence of anti-social behaviour and the need for evictions.

In order to build a full picture of need and develop workable solutions, the Programme joined with a range of partners, including:

- Communities and Local Government (CLG);
- Ministry of Justice National Offender Management Service (NOMS);
- Housing Corporation;
- Department of Health's Care Services Improvement Partnership (CSIP); and
- National Treatment Agency (NTA) for Substance Misuse.

Together they have worked with a national stakeholder group from the housing and drugs fields on a programme of research looking at existing projects and partnerships to identify best practice and solutions.

Because one size does not fit all...
This work, which took place between September 2007 and January 2008, centred on 13 case studies of cross-functional drug and housing projects across England. Crucially, the views of service users were included from the planning stage, and their needs were taken as the starting point for developing solutions.

What the results showed was that the best outcomes come from services that are flexible enough to meet individual needs. Drug users live in all types of housing and present with a variety of complex issues. Their needs also change with time. At different stages of treatment and recovery they may need different services, from managing their drug use to managing debt or rebuilding relationships with families and friends. Housing and related support services must be flexible enough to respond to any or all of these needs.

Translating words into action
The case studies identified several common drivers, which can trigger change and help bring about joined-up service delivery. These included:
• local 'champions' – people or organisations who take ownership of issues around housing for drug users;
• needs-led assessment, a comprehensive review of local provision to identify where needs are not being met;
• service user involvement, to identify the changing needs of individual drug users; and
• local structures and delivery groups, to take practice forward and bring key agencies together.

Also highlighted were effective methods for assessing the wide spectrum of needs and how they can be met. These included mapping what housing and housing support services are available, carrying out gap analysis to identify where user needs are not being met, and reviewing other sources of advice, care and support available locally.

Integrated approach
However, there is currently no common structure which brings housing and drugs together at a local level to meet the varying and complex needs of drug users. It has remained for local areas to decide how they address this, for example through adoption or adaptation of existing partnerships. The key focus for DIP's housing strategy is therefore to ensure that all the services and agencies responsible for planning, commissioning and service delivery embed housing and related support for drug users within their respective plans.

Comprehensive Rent Deposit Model
One approach which highlights the importance of joined-up working is the rent deposit scheme. This involves paying a deposit or advance on rent on behalf of service users, or a bond guaranteeing the housing provider against damage. In 2005 the Programme funded 13 Drug Action Teams to develop a Comprehensive Rent Deposit Model appropriate for drug users.

Initial findings showed that, as well as the financial element, a successful scheme requires a high level of contact and engagement from drug service workers, especially for those leaving treatment or prison. Specialist assessment of housing needs was also identified as an important factor, as was ongoing tenancy management.

Existing rent deposit schemes also highlighted the importance of practical help with issues such as negotiating the tenancy, the housing benefit application, connection of gas and electricity, and getting to know the local area.

Source: www.drugs.gov.uk

Welfare to Work

The Governments proposal to support more problem drug users into employment could be a significant leap forward in drug treatment. We believe that employment is crucial to maximising the gains made in the treatment process. To that end, greater partnership between treatment providers and employment services is highly desirable.

The greater emphasis on tailored support to meet individual needs, including help with skills, health, childcare, financial support and accessing appropriate training is a key element, also, that clients will be treated as individuals with individual needs is a positive step change. A focus on individual circumstances is

vital if treatment and action on unemployment are to be successful; how the specific needs of the individual are identified and planned for is crucial to that success.

The opportunity to make employment a real option in the rehabilitation of problem drug users can be realised through the careful matching of treatment with welfare to work programmes. We know through the Progress2Work programme, that a great deal can be achieved by doing this.

The treatment of problem drug use is rarely a linear or quick process. Relapse is common and many people have multiple attempts, often over many years, before they achieve abstinence from drugs. It is also not the case that being abstinent is a necessary precursor to being able to work. Being in treatment can enable a problem drug user to work and we would see employment as a necessary part of the recovery process during treatment not as something that can only be successful when treatment ends. However, that may not be the view of many employers.

The welfare reform bill places employers at the heart of the reform and is aiming for major employers, in both the private and public sectors, to offer a quarter of a million job opportunities. However, it appears the biggest challenge is the engagement of employers. There can be significant resistance to the idea that problem drug users in treatment can be reliable and effective employees. Many problem drug users have been years out of the employment market, some have never been employed, and explaining the missing time as well as overcoming shortages in skill and experience are major problems.

We would therefore be extremely grateful if you would spend a short time in completing the brief questionnaire attached and return it to us by 13 February 2009. Your answers will be treated in the strictest confidence and a copy of the evaluated feedback will be provided to all who respond.

Many thanks for your assistance.

Our Links with Europe .....

4th EXASS Net meeting – Moscow – 30-31 October 2008.

The Federal Drugs Control Service (FDCS) kindly invited EXASS Net to stage the 4th meeting in Moscow. Visits were arranged to centres/institutions at both federal and municipal level. 1.5 million class A substance misusers in Russia highlights the severe problems facing the FDCS. Likewise, HIV rates are very significant with 50% HIV prevalence reported in some cities within one or two years. The Russian Federation does not recognise the recommendations made across Europe such as substitution programmes, low threshold services and needle exchange which have all played an active role in dealing with substance misuse.

Patients with alcohol problems were treated alongside chaotic opiate users in the same clinics, however, problematic use of other drugs was not evident during our visits. Relapse appeared commonplace after discharge, in particularly circumstances such as the patient not local, and travelling a prolonged and time consuming journey home. Promoting a multi-agency approach would help to stem chaotic substance misuse currently impacting on the country, although information sharing was evident sufficient throughcare is far from guaranteed as there is no requirement by the patient to continue treatment on discharge. The Municipal Centre in Moscow provides treatment and support for problematic substances misusers who are of local proximity therefore are also in a position to offer an out-patient service. The group rooms observed suggested Cognitive Behaviourable Therapy (CBT) was a prominent intervention with evidence of strong religious connotations.

At the National Research Centre on Addictions discussions with the head doctors on various aspects of treatment, throughcare and continued care was followed by a tour of the hospital wards which enabled a brief dialogue with the staff. The Moscow Scientific and Practical Centre on Addictions provides emergency care, in-patient treatment and rehabilitation services. Physiotherapeutic treatment is underpinned by counselling and interventions such as electrically induced sleep, hydro-thermal treatment etc. It was reported that treatment at the centres visited was free however, considering the significant problem of substance misuse none of the centres were full. The fact that problematic substance misusers are registered and it can take 5 years to be taken off the register may have a negative influence on potential patients.

The final visit of the day was to the Moscow State Technical University where it was reported during a presentation that drug testing in the army was paramount in addressing substance misuse. During the presentation surrounding the prevention of drug addictions among young people it also emerged that introducing drug testing in schools was a medium term goal and universities on a broader scale. However, the consequences for students testing positive or those who refuse to be tested was not clear. The presentation was followed by a demonstration of a new hi-tech drug testing apparatus. The ability to test on substances including alcohol and nicotine was displayed and uniquely, provided evidence of substance misuse dating back more than two months.

A presentation describing the organisation of treatment services in the penitentioniary system described how Primary jails provided psycho-therapy treatment led by a Narcologist. However, lifeskills do not appear to be addressed leaving individuals with limited coping mechanisms. With little potential of finding employment and no practical support on release people leaving prison face a difficult future. Low self esteem was reported. As with the institutions visited experiences were highlighted where patients had abstained for prolonged periods and relapsing shortly after release. Although all problematic substance misusers are able to access drug and rehabilitation courses the need for continued aftercare was clearly evident. The FDCS are clearly concerned by the supply and demand of heroin in to the country and are clearly making significant efforts to combat trafficking. It was reported that 40.000 professionals are involved in working across the Russian Federation carrying out various functions in the fight against illicit drugs.

We were made very welcome during the visit to the Russian Federation and the visits were detailed. It was a very professional and well organised event. EXASS Net have expressed their sincere gratitude to the FDCS of the Russian Federation, the National Research Centre on Addictions, the City of Moscow's Scientific and Practical Centre on Addictions and the Moscow State Technical University.

EVENTS

UK Drug Workers Forum Regional Events 2009

- 24 March - London
- 19 May - Liverpool / Wales – details to be advised

- **National Drug Treatment Conference**
  19-20 March 2009, London. **Contact**: www.exchangesupplies.org, tel: 01305 262244

- **14th National Conference: Working with Drug and Alcohol Users in Primary Care**
  7-8 May 2009, Liverpool. Contact: http://www.healthcare-events.co.uk/conf/booking.php?action=home&id=209

- **UK Drug Workers Forum Annual National Conference 2009 - 13-14 October - York**
  Annual National Conference of the UK Drug Workers Forum. Aimed at all workers in the drugs field, the event will address current issues, new developments and best practice relevant to professional practice.
  Contact: UK Drug Workers Forum - Tel: 01904 898069, Fax: 01904 898715
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