Drink and Drugs News
November 2020
ISSN 1755-6236

DDN

ENOUGH EXCUSES
Time to change the narrative around drug-related deaths

THE RIGHT CONNECTIONS
Reshaping the way we look at recovery

LIFE THROUGH YOUR OWN LENS

OPENING HONEST DIALOGUES WITH MARGINALISED COMMUNITIES

LEVEL 2
NOW LIVE

Certificated e-learning for needle and syringe programme workers

An open access training resource developed as part of the Exchange Supplies social mission to maximise the impact of harm reduction.

Grounded in NICE guidance PH52 for needle and syringe programmes, the training builds to qualify workers at all levels of service provision.

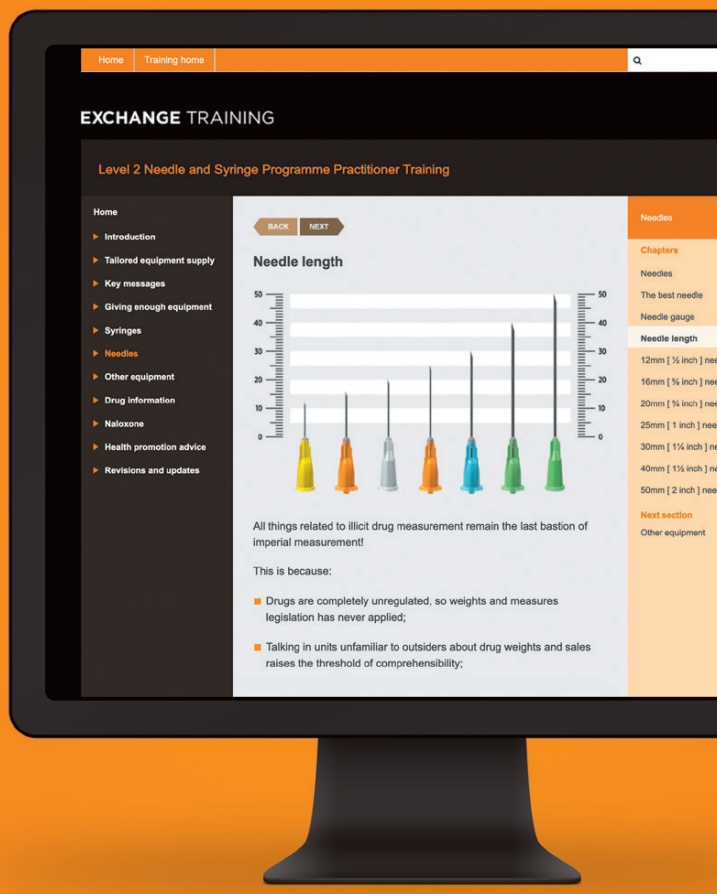
Level 1 is a foundation course for needle and syringe programme practitioners and covers the core attitudes, knowledge, and skills required to distribute injecting equipment, with over 200 certificates of qualification issued to NSP practitioners to date.

Level 2 – IS NOW LIVE and covers the attitudes, knowledge, and skills required to distribute tailored equipment supply in a Level 2 needle and syringe programme.

With over 50 pages of information and video, the course trains practitioners to deliver bespoke injecting equipment tailored to the needs of the individual, and health promotion advice and information on how to reduce the harm caused by injecting drugs.

We are working to write a Level 3 module that will be a full and comprehensive online training for specialist needle and syringe programme workers.

Suggestions and feedback welcome:
please send to andrew@exchangesupplies.org



For full details visit training.exchangesupplies.org

EXCHANGE SUPPLIES
MAKING INJECTING SAFER

DDN

Drink and Drugs News is published by **CJ Wellings Ltd**, Romney House, School Road, Ashford, Kent TN27 0LT
t: 0845 299 3429

Editor: Claire Brown
e: claire@cjwellings.com

Advertising manager: Ian Ralph
e: ian@cjwellings.com

Reporter: David Gilliver
e: david@cjwellings.com

Designer: Jez Tucker
e: jez@cjwellings.com

Subscriptions:
e: subs@cjwellings.com

website:
www.drinkanddrugsnews.com

Website support by wiredupwales.com

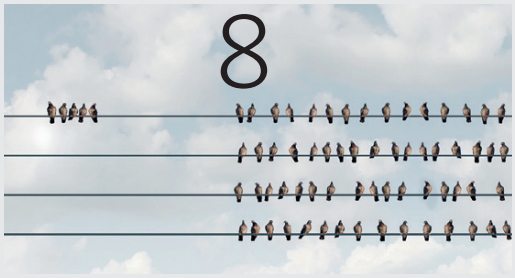
Printed on environmentally friendly paper by the Manson Group Ltd

Cover by: agsandrew/iStock

IN THIS ISSUE

ON THE COVER: Dialogue and support for marginalised communities

INSIDE



COMMUNITIES AND PARTNERS

The community has lost one of its harm reduction pioneers, **Gill Bradbury**. Gill was a skilled nurse, energetic activist and passionate about putting harm reduction into practice. A deeply caring person, she put saving lives before any political dogma – a spirit that will live on and inspire us to do all we can to stop drug-related deaths.

DDN is a self-funded independent publication. Our bespoke partnership packages provide an opportunity to work closely with the magazine. Please get in touch to find out more.

'How can we change appalling statistics?'

Writing and reading about drug-related deaths is depressing for all of us – the inevitability year after year, when policy doesn't follow the evidence. The question is (as raised on many pages of this issue) how can we affect the situation? How can we do things differently, and make others *see* things differently, to change these appalling statistics? It's no mystery that tackling underlying healthcare discrimination should be a primary focus.

Sharing the 'safe supply' scheme from his home in British Columbia, Bill Nelles (p16) charts the journey of one straightforward harm reduction approach, through the challenges of risk assessment, scepticism and moral dilemma, to finally become official health policy. He hopes that the UK could follow suit with a similar approach – can we believe we will? The fact that Peter Krykant was challenged by police for providing his life-saving drug consumption van (p5) shows how far we have to go.

The groundswell of activism and appetite for collaboration could transform this dismal landscape. We have the evidence base and experience, and we have many minds thinking alike. We have the challenges of COVID to contend with, as well as budget worries. But let's not allow inertia to be a reason why things didn't change.

Claire Brown, editor

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

Another record high for England and Wales drug deaths

There were 4,393 deaths related to drug poisoning registered in England and Wales last year, according to the Office for National Statistics (ONS), just up from 2018's record figure of 4,359 (*DDN*, September 2019, page 4). While men once again men accounted for around two thirds of the deaths, the rate of fatalities among women has now increased for ten years in a row. More than half of all poisonings involved an opiate.

Just under 2,900 of the deaths were as a result of drug misuse, representing a slight – but 'not statistically significant' – fall from last year. As in previous years, the highest rate of drug misuse deaths was in the North East, at 95 deaths per million people, compared to 33.6 deaths per million in the East of England. Rates of drug poisoning deaths have been consistently higher in the most deprived areas, particularly among people in their forties, while deaths involving cocaine have increased for eight years in a row. Poisonings involving cocaine have risen by more than 26 per cent for women and 7 per cent for men since last year, while poisonings involving NPS and fentanyl have remained stable.

Drug-related poisoning rates have been on a 'steep upward trend' since 2012, says ONS, in line with trajectories in Scotland and Northern Europe. The age at which most people died from drug misuse has also continued to increase over time, with 20 to 29-year-olds having the highest rates during the first decade of figures, 30 to 39-year-olds between 2003 and 2015, and 40 to 49-year-olds-since then. Change Grow Live chief executive Mark Moody said that a 'critical tipping point' had now been reached. 'The drug-related crisis has been worsening for over a decade. At the heart of the trend is a perfect storm of factors – disinvestment, an ageing population of people using drugs, and increasingly complex health needs. Adding to these challenges, the global coronavirus pandemic has, and continues to, impact vulnerable people most.' An 'evidence-based system' was the only way out of the crisis, he stated.

It was clear that cocaine use had increased 'exponentially' in the last decade, said We Are With You deputy CEO Laura Bunt, with many people remaining unaware of the potential harms. 'We need much better education early on in schools and throughout the population on how to use drugs in the safest way possible and what support is out there. These figures are stark, but with some simple changes they can be brought down. The evidence is clear on what works; hopefully there is now the will to implement it.'

'The reality is that local alcohol and drug services are operating under immense pressure as our funding continues to decrease,' added executive director at Humankind, Karen Tyrell, while the dissolution of PHE made it 'feel like we have now come to a critical point'. The sector needed to focus on keeping harm reduction services open, getting naloxone to as many people as possible, and being flexible in its approach to prescribed medication, she stressed.

'We are at a critical tipping point... An evidence-based system is the only way out of the crisis.'

MARK MOODY

Deaths related to drug poisoning in England and Wales: 2019 registrations at https://www.ons.gov.uk/

Cold weather payments 'fall short'

LOCAL AUTHORITIES will receive £10m in cold weather payments to help keep rough sleepers safe over the winter, the government has announced, with an additional £2m earmarked for faith and community groups to provide emergency accommodation. Guidance produced in partnership with PHE, Homeless Link and Housing Justice will also be issued to the homelessness sector to support shelters to open more safely. 'As we approach winter, we are focusing on the best way to protect rough sleepers from the cold weather and coronavirus,' said communities secretary Robert Jenrick.

Crisis chief executive Jon Sparkes, however, stated that the money falls short 'of the bold action we need' to keep people safe. 'Back in March the government rightly decided that night shelters and hostels were not a safe environment for people during the pandemic. It's completely unacceptable that this approach should now change as we go into winter when the threat remains the same. We must not force people to choose between freezing on the street or a shelter, when both needlessly put lives at risk.' The government needed to provide local authorities with the money to ensure everyone forced to sleep rough has access to safe, self-contained accommodation, he stressed. 'Anything but this is risking lives. We urgently need the government to see sense on this matter and keep winter night shelters closed.'

'Those forced to sleep rough must have access to safe, self-contained accommodation.'

JON SPARKES

Scots drug admissions up

THERE HAS BEEN A MORE-THAN-THREEFOLD INCREASE in drug-related hospital stays in Scotland since 1996, according to the latest Public Health Scotland figures. The rate increased from 73 to 260 stays per 100,000 population between 1996-97 and 2018-19, with drug-related acute hospital stays increasing from 51 to 219 per 100,000 – with a 'sharper increase' in recent years. Drug-related psychiatric hospital stays have also increased from 29 to 41 per 100,000 since 2014-15, 'following a period of relative stability'. The most common drug associated with stays was opioids followed by 'multiple/other drugs,' while the most common age range was 35-44, with rates increasing ninefold among this group since 1996. *Drug-related hospital statistics at beta.isdscotland.org/*

CAP consults on tighter gambling ad codes

The Committee of Advertising Practice (CAP) has launched a public consultation on strengthening the UK Advertising Codes related to gambling. In particular, the CAP is looking at barring the use of celebrities or characters likely to be followed by, or 'appeal strongly' to, under-18s. This would have 'significant implications' for companies looking to use prominent sports figures or social media influencers to promote their brands, the committee states.

The proposals are designed to better protect children and vulnerable people from potential gambling-related harm, and have been developed partly in response to GambleAware research which found that even advertising that abides by the existing codes has 'more potential than previously understood' to have an adverse impact on young and vulnerable people. The All Party Parliamentary Group (APPG) for Gambling Related Harm recently called for a ban on all gambling advertising, while a report from the House of Commons Public Accounts Committee stated that oversight of the gambling industry by the Department for Digital, Culture, Media & Sport (DCMS) and the Gambling Commission was 'weak' and 'complacent' (*DDN*, July/August, page 4).

Among the other proposals set out in the CAP consultation are a 'strong' test to identify content that would appeal to under-18s. While child-orientated content like superheroes or cartoon characters is already banned, the new regulations would be widened to cover characters' behaviour, language, clothing and appearance. Guidance would also be strengthened to prohibit the use of humour to play down gambling risks, 'unrealistic' portrayals of winners, and the presentation of complex bets in a way that emphasises skill or intelligence to suggest 'a level of control over the bet that is unlikely to apply in practice'.

> 'Even advertising that abides by the existing codes has more potential than previously understood to have an adverse impact on young and vulnerable people.'

Consultation at https://www.asa.org.uk/resource/gambling-appeal-consultation.html

Well aware

THE THEME of this year's Alcohol Awareness Week, which runs from 16-22 November, is alcohol and mental health, including 'the best ways to look after ourselves and those we love during a year of great change and uncertainty'. Around one in four people in the UK experience mental health issues each year, with most unaware of the link between alcohol and poor mental health, say the week's coordinators Alcohol Change UK. 'Alcohol harm can affect any one of us, from any walk of life. But with improved understanding, forward-thinking policy and better support and treatment we can change and save lives,' the organisation says.

More information at https://alcoholchange.org.uk/get-involved/campaigns/alcohol-awareness-week-1

Consumption clarification

POLICE SCOTLAND have issued a statement following reports that Peter Krykant, who has been operating a mobile drug consumption van in Glasgow, had been arrested. 'A 43-year-old man was charged for obstructing police officers carrying out their duties in respect of the Misuse of Drugs Act,' said assistant chief constable for partnerships, prevention and community wellbeing, Gary Ritchie. 'He was not arrested and a report will be submitted to the Procurator Fiscal in due course.' Police Scotland's drug strategy was 'based on principles of harm reduction' and focused on engaging with partners to 'ensure that those whose lives are affected by drug use receive the appropriate care from health and support services', he added.

'This situation is deeply regrettable and unnecessary,' the Scottish Drugs Forum commented. 'There has been little or no public, business or media complaint about the service provided. In other words, there is no practical barrier to providing the service excepting the legal dilemma facing authorities in Scotland. A better equipped service staffed by medical professionals and integrated with other support and treatment services is a much preferable solution, and the only possible sustainable service solution in the long term.'

Peter Krykant, who operates a mobile drug consumption van, was charged with obstructing police officers. Pic: www.dailyrecord.co.uk

Local News

Controlled diversions
West Midlands PCC David Jamieson is funding a new scheme to divert anyone caught for possession of a controlled substance away from the criminal justice system. The DIVERT pilot will see people attend drug outreach or education instead and not receive a criminal record.

Virtual festivities
Adfam's traditional Christmas carol concert will be a virtual celebration this year, with supporters able to watch from the comfort of their homes. The event, on 9 December, will also feature celebrity guests reading winning competition entries. *adfam.org.uk*

Forward momentum
Forward Leeds has created a new team of mental health professionals to work with people sleeping rough or facing homelessness. 'Many of the those living on the streets in Leeds have suffered multiple traumas in the past,' said operational manager Anne Hobbs.

ENOUGH EXCUSES

Simply blaming an ageing cohort or pre-devolution economic policies for Scotland's shameful levels of drug-related deaths won't cut it anymore, say **Barry Sheridan** and **Iain McPhee**

Igor Dutina | Dreamstime.com

For more than a decade drug-related deaths (DRDs) in Scotland have increased, with the available evidence indicating poor alcohol and drug service outcomes in comparison to the UK and the rest of Europe. Between 2007 and 2019 the Scottish Government cut budgets for alcohol and drug services from £114m to £53.8m per year.

In this article we explain how Scottish Government funding and policy decisions, centralising service provision, and closing third sector service providers – while relying on unpaid volunteers in recovery – has contributed to increased risk of DRD among marginalised communities.

In assessing evidence that challenged the Scottish Government narrative that DRD increases were attributable to a legacy of UK government economic policies before Scottish devolution in 1999, or that increased DRDs could be explained by an ageing cohort, we reviewed the 2009 Audit Scotland report on drug and alcohol service provision. This report was published after the Scottish Government published the *Road to recovery* strategy in 2008 – this strategy concentrated on drug-free recovery, with a clear focus on the concept of recovery capital. The adoption of a narrow individualised conceptual approach to measuring recovery has clearly failed to reduce DRDs. The strategy largely ignored structural and environmental risk factors for problematic drug use, and increased risk of DRDs.

The analysis in our paper published in *Drugs and Alcohol Today* uses the 2009 Audit Scotland report *Drugs and alcohol services* to make comparisons with the 2019 update report *(see box opposite)*. The 2009 report made six recommendations on treatment effectiveness – setting clear national minimum standards for a range of services, clear accountability of service governance, assessment of local need, service specifications on quality requirements, clear criterion on demonstrating treatment effectiveness, and, finally and most importantly, to use the Audit Scotland 2009 checklist to help improve delivery and impact of drug and alcohol services using a joined up consistent approach.

The 2019 report did not follow up on the recommendations in the 2009 report but chose to focus on naloxone provision, needle provision, and framing increases in DRDs as linked to an ageing cohort. The 2019 report indicates a 71 per cent increase in DRDs since 2009 and suggests that the average annual funding for services by the Scottish Government was £73.8m for 2018-19. These statements require deeper analysis and explanation.

NALOXONE

Naloxone has an impact on people who experience an overdose of opiates. However, a large number of DRDs are – from autopsy and toxicology reports – poly-drug users, which reduces the effectiveness of naloxone in preventing overdose.

'In an advanced nation such as Scotland we should not consider being over 35 part of an ageing cohort.'

NEEDLE PROVISION

The uptake of syringes is not an indication that needles are provided to the target population, i.e. those most at risk of DRDs – poly users of opiates and benzodiazepines.

The existing data indicates that a large percentage of service providers distribute injecting equipment to non-problematic drug injectors and will include people injecting performance enhancing substances.

The Misuse of Drugs 1971 Act has been used by the Scottish Government as an excuse for not implementing a proposed safe injection facility (SIF). Evidence indicates that drug related deaths are more prevalent in urban communities characterised by deprivation. Therefore the proposed first SIF site, Glasgow city centre, will have little impact on the target group (people not frequenting Glasgow city centre to buy drugs) most at risk of DRD. We believe that there should be multiple SIFs at the sites where the deaths are occurring.

AGEING COHORTS

In an advanced nation such as Scotland we should not consider being over 35 part of an ageing cohort. In other areas of public health, such as heart disease, obesity, or diabetes, being 35 or over would not be posited as a major contributing factor to explain a rise in death.

For the Scottish Government to attribute increased DRDs to a legacy of Westminster pre-devolution economic policies is shameful. We cannot attribute the stark increases in DRDs to the economic policies of the UK government more than twenty years ago or to an ageing cohort. Thirty percent of drug related deaths occur among an age group who entered the labour market post-devolution in 1999, when economic policies were devolved to the Scottish Parliament.

Drug-related deaths have increased by 470 per cent since 1996. Around half of DRDs occur in the most deprived communities, while 4 per of deaths occur in the most affluent areas. Using the WHO burden of disease formula, the rates of DRDs within deprived communities are similar to the prevalence rates for heart disease and strokes. There would be a national outcry if the same number of deaths occurred in the population for any other health-related mortality factor.

FUNDING

Examining the Scottish Government data on alcohol and drugs services funding indicates that there has been more than a 50 per cent cut in funding to services since 2007-08. The 2019 report suggests that an annual funding of £73.8m per year is being made available to services. However, the actual figure is £53.8m per annum – the additional £20m accounts for £10m per year allocated over two years to the Drug Deaths Taskforce. There is little evidence that monies allocated to the Drug Deaths Taskforce have significantly impacted on reducing deaths in the communities where drug deaths are occurring.

Recommendations made in 2009 by Audit Scotland were ignored. If these recommendations were acknowledged by the Scottish Government and implemented, they may have improved outcomes and prevented unnecessary drug related deaths.

In short, cutting funding, centralising services, and ignoring accountability for making these cuts and changes to service provision, increased risk factors. We cannot change the policy and funding decisions that have been made. But we recommend that a meaningful and collaborative approach is taken by statutory and non-statutory agencies beyond addiction services to implement effective system changes recommended in the 2009 Audit Scotland report. No longer can services be designed to suit the needs of the organisations that commission, provide and evaluate their own services.

Specialists, non-specialists, and communities (beyond recovery communities and families) must be at the heart of this collaborative approach, adopting an inclusive, honest, and open dialogue. This dialogue has to begin by admitting that current specialist alcohol and drugs services no longer have the legitimacy to offer solutions. Only then can we prevent further increases in DRDs that impact greatest on the most marginalised communities in Scotland.

AUDIT Scotland ten years on: https://doi.org/10.1108/DAT-05-2020-0024

Barry Sheridan is independent consultant and researcher, affiliated to the University of the West of Scotland. Iain McPhee is senior lecturer alcohol and drug studies at the School of Education and Social Sciences, UWS.

DRUGS AND ALCOHOL SERVICES – THEN AND NOW

1. The HEAT standards used by Scottish Government concentrate on only one measure, that of treatment waiting times. The 2009 Audit Scotland report indicates that no clear minimum standards of treatment outcome efficacy were used, and this remains the situation in 2020.
2. There remains no clear separation between service provider and service purchaser, thus poor service performance in 2009 was unaccountable. This is still the case in 2020.
3. There are no measures in place to assess local need informing local decision making in 2020. All decisions remain top down and centralised. We accept that the NHS (ISD) DAISy tool is due to be implemented in December 2020 and will be helpful in assessing individual risk factors, however this has taken seven years to design. It will not fully assess local need – the tool records data on those individuals who access services, not on those at risk who do not.
4. Voluntary sector services are commissioned on short-term contract cycles negating the opportunity to allow commissioned services to adopt a long-term approach. Longer contracts would, we believe, allow these services to deliver better treatment outcomes where DRDs are occurring.
5. There is a lack of robust information on opiate replacement therapy, unit treatment costs and treatment outcome information. This local and national data is available in England but not in Scotland, meaning that the Scottish Government is unable to develop information that could improve service provision, performance management, accountability, and service outcomes. A de-professionalisation of the sector has occurred due to severe funding cuts and encouraging low or unpaid volunteers to provide recovery support. While we welcome the current emphasis on developing recovery communities who offer a vital resource, they should not be a low-cost replacement for skilled workers.
6. The 2009 Audit Scotland checklist was not mentioned in the 2019 Audit Scotland report, relating to governance. Performance and evidence-based services were not discussed in the 2019 Audit Scotland report.

On the margins

Peter Keeling hears from April Wareham of Working with Everyone about how marginalised communities have been coping during lockdown

Working with Everyone is a group of people with lived experience of drug use and treatment who initially came together to use their expertise to improve the drug treatment and recovery systems. As time went on they realised that many problems existed way beyond drug treatment and affected other marginalised communities, and so the scope of the organisation was expanded.

April Wareham is leading research for NHS England and the University of Bradford on how marginalised communities – who are disproportionately impacted by health inequalities – have coped under COVID-19 restrictions. Over the summer, April and her team interviewed 150 people from marginalised communities, including people who use drugs, people with lived experience of the justice system, and people who are or have been street homeless.

Tell us a bit about Working with Everyone and how the research came about

'One of the reasons we're called Working with Everyone is, as a group of people with lived experience of drug use and treatment, we have all made different decisions about our own lives. Some of us are abstinent, and some of us aren't. We want it to be about everyone, so if someone presents for treatment they can get what they need, whether it's clean syringes or full blown, bells-and-whistles rehab.

When lockdown started, we knew quite quickly that we wanted to capture the stories from marginalised groups about their experiences – we've already worked with these groups quite a bit. NHS England approached us to do a piece of engagement work and suddenly the project grew legs when the University of Bradford also got some funding to interview refugees.'

When we talk about 'marginalised groups', who do we mean?

'We work with everyone from sex workers and people who use drugs to armed forces veterans and people who are street homeless, but they have so much in common around their experiences of healthcare. We're all really small groups so we're much stronger if we can say together, "This is the problem". And in any case there's often significant overlap between these groups, as well as with refugees and travellers.

We originally went through the list of groups that had poorer health outcomes, and crossed off the ones that had existing mechanisms to interact with the system. So we were left with what looked like a very random group of people. And, I've got to say, I thought it would be a disaster – I thought no one would talk to us. But it wasn't, it was really good. So we had people from the refugee community sitting next to people who have enormous criminal records and have used drugs all their life – people had so much in common around their experiences of healthcare.'

What was it like for marginalised groups' health and wellbeing before the pandemic?

'We have an incredible burden of both physical and mental health in these communities. People identify to us as someone who uses drugs or as a refugee, but they could very often be classed as physically disabled. And the mental health diagnoses – they are just at phenomenal rates.

Many people we spoke to weren't even registered with a GP at the beginning of the pandemic. And people also change GPs a lot, sometimes because they are living a transient lifestyle but also because they're having to move around to survive. We're talking about people who will say they only approach healthcare when it's either that or die. People have actually told us, "Everyone hates us and we know it – so we're not going to engage".'

Services had to adapt their support offer rapidly during the crisis. Has the greater use of telephone and digital support worked for marginalised groups? What are some of the challenges?

'It's been a bit variable. Some people have literally said they've never had so much contact with their keyworker, because an effort has been made to reach out to people. I came across one case where they had mobile data and they had the tech, and they wanted to change GP. And the GP said, "Great, we'll send you forms so you can print them out and sign them". Well, I might have a smartphone, I might have data, but I

Skypixel | Dreamstime.com

WORKING WITH EVERYONE

IMPROVING OUTCOMES FOR ALL

‘Too often people end up trying to fix someone’s life through the lens of their own life, wrongly assuming that the things that are important to them are important to others.’

APRIL WAREHAM

don’t have a printer.

At the beginning of the pandemic people were so glad to be able to get any kind of support around mental health. But people are now describing it as being a ‘holding pattern’ and they’re not able to do the serious work. I think as time goes on, people are going to be less satisfied with some aspects of this, because we know from the evidence that it’s almost irrelevant what model of drug treatment we use – the thing that really matters is the personal connection between the person and their therapist or worker.

I think those personal connections are more difficult to maintain over the internet, but they are also going to be almost impossible to build over the internet. It’s very different calling the keyworker you’ve had for ten years and having a laugh to meeting a therapist for the first time digitally.

And on the subject of the digital divide, we have to think about not just safety and privacy, but also about appropriateness. I work with people living in what you might call overcrowded conditions. So we have an entire family living in a caravan, or we have shared houses. We need to be thinking, is it appropriate for me to ask you about your gynaecological health when your children are in the room?’

What was it like conducting this research with COVID-19 restrictions in place?

‘I really underestimated how isolated and lonely people were. Interactions I thought would be a ten-minute conversation ended up taking three hours, because I was the first person they’d spoken to. It made me really reflect on how important things like volunteering or being on a service-user council are to people. And I think that’s something we need to carry forward from this. Maybe for someone working in the system, they just need four volunteers one afternoon to open up a building, and that’s pulled due to COVID – but we also need to realise that those volunteers need that afternoon themselves. It’s important to them.’

Finally, how would you like your research to inform better policies and practices in a world where some of the changes caused by the pandemic are here to stay?

‘I’d like to see the system starting to address some of its underlying assumptions. Too often people end up trying to fix someone’s life through the lens of their own life, wrongly assuming that the things that are important to them are important to others. Under lockdown, that’s became blatantly obvious. Just come and ask us what matters, don’t make the assumptions.

It’s about our priorities at both an individual and a collective level – they might not be NHS England’s priorities or the drug treatment system’s priorities. Someone might come into drug treatment and, actually, the best thing we can do for them is sort out their benefits claim. It’s about what matters to that person and also, when we’re thinking about service design and systemic change, what is important to these communities. Let’s just remember that people are people, and let them assign their own priorities.’

To find out more about Working with Everyone and this research contact April at april.wareham@yahoo.com

Peter Keeling is campaigns officer at Collective Voice

WELL WORTH IT

The Worth Women's Project is bringing much-needed support to vulnerable women in East Kent, says **Ann Humphreys**

Oleksandra Troian | Dreamstime.com

In 2019, my team and I realised that the retention rates for our female clients were far lower than for their male counterparts. I work for Forward's criminal justice team, part of the charity's East Kent community drug and alcohol service, and we decided to explore why women weren't engaging as much. Criminal justice worker Tony Riches visited a women's centre in Brighton and the team read the *Corston report*, a 2007 review into the treatment of vulnerable women in the criminal justice system. We also discussed the issue with other professionals, such as the women's lead at a local probation service.

We realised that low engagement could be linked to the fact that many female clients – in addition to having the multiple and complex needs that all clients have – had complicated relationships with the authorities and related service providers. This was particularly pronounced if they'd been through a traumatic experience they felt was either caused or exacerbated by these organisations, such as having children taken away by social services. It also became clear that our area needed the kind of centre Tony had visited in Brighton – despite this being over 50 miles away, it was the closest option of its kind for our clients.

The team put together some ideas on how to address these issues and improve engagement, but it became clear that the scope of the work involved meant it would need to become a standalone project with funding to cover the cost of dedicated workers. I did some research and discovered that Kent's police and crime commissioner had a pot of funding we could apply to, which was part of the Violence Reduction Challenge (VRC). I approached our fundraising team and together we put together a proposal for funding – shortly after, we were thrilled to discover we'd been awarded the funds!

The Worth Women's Project was born. Initially delivered to women in Margate, the project aims to protect women by reducing their vulnerability to threats of violence. It is targeted at women in contact with the criminal justice system who may have experienced domestic violence, substance misuse issues, trauma, involvement in violent crime, or any combination of these factors.

The project was initially delivered through face-to-face workshop sessions exploring healthy relationships, attitudes towards crime, safe coping, decision making, recognising danger and managing potential pitfalls. Using trauma-informed approaches and evidence-based practices, project participants learned more about their own behaviour and developed new skills to challenge unhealthy responses, building resilience and preventing risk from harm.

When COVID hit, the project co-ordinators continued to work remotely with one-to-one sessions over the phone and twice-weekly Zoom coffee mornings – this was particularly important given the rise in domestic violence as a result of lockdown. More than 60 women have engaged to date, ranging in age from 22 to 76. Clients completed forms before and after the interventions which measured depression, anxiety, mental wellbeing, self-worth, resilience and attitudes to crime. The project was found to have statistically significant improvements on all of these measures, and there has also been extremely positive informal feedback from participants.

'I just wanted to thank you for all the help and support you have given me over the past few months,' said one client, Michele. 'Without your advice, and being a welcoming voice at any time I needed a chat or was having a bad day emotionally, I don't think I would have come this far.'

'I live on my own, having been domestically abused in the past, along with suffering mental health and alcohol addiction,' added Jackie. 'I have found the Worth project to be invaluable during the pandemic. I received phone calls from Victoria every day. To me this was an absolute lifeline, as being in isolation there are times that I am not able to go outside for days. I am sure there are many people like myself who have benefited from this and I would like to say thank you.'

> 'When COVID hit, the project co-ordinators continued to work remotely with one-to-one sessions... this was particularly important given the rise in domestic violence as a result of lockdown.'

The project is ongoing and there are still challenges, including our ability to reach women still in custody awaiting release, the fact that a lot of referrals we receive are not suitable for our service, and that funding is set to finish at the end of the year. However, we are optimistic about the future and proud of the fantastic work done so far, particularly the team's passion for the project – our staff have been truly amazing. You can tell that the service users know how much the team cares, which comes across in all of the feedback we've had.

Ann Humphreys is criminal justice team leader – East Kent at The Forward Trust



A DARK PICTURE

The latest drug death statistics provoked more calls for action from the drugs, alcohol and justice parliamentary group

Presenting the latest statistics on drug-related deaths in England and Wales, Asim Butt from the Office for National Statistics (ONS) gave data to confirm the inevitable-seeming trend: that deprived areas have significantly higher mortality rates, with a significant north-south divide (see news, page 3). The North East once again topped the table of deaths in 2019 – which of course did not include any more recent data relating to coronavirus.

The age at which people were dying was increasing, following 'Generation X' into middle age. A substantial increase in cocaine poisonings included a steep rise in female mortality.

'Year after year we have ONS presentations, with the heartbreak, the families, the people... presenting evidence doesn't seem to make much difference,' said Alex Boyt. 'This government is not strong on compassion, with cuts and health inequalities. We're preaching to the converted here – we need to be reaching some different minds.'

Sunny Dhadley suggested that we needed to be much cleverer in how we use resources to support society's most vulnerable, starting with joint commissioning and considering alternative models of funding. 'It's time for us to do something radically different, and to join services together,' he said.

'We need to remind ourselves that behind the numbers are people, and often a grieving family,' said Lucy Holmes from Alcohol Change UK. Alcohol-specific deaths (whose statistics for 2019 would not be released until 2021) were many times higher, with many hidden deaths, and shouldn't be the poor relation. 'All of these deaths are preventable,' she added. Homelessness outreach teams should be trained and skilled, and ACUK's *Blue Light manual* had the appropriate training on change-resistant drinkers.

With deaths increasing for more than a decade, Iain MacPhee and Barry Sheridan had written a paper to offer explanations (see *Enough Excuses*, page 6). Lack of information in Scotland had made it difficult to use data to make decisions, said MacPhee, but it needed to be highlighted that naloxone had no effect on some of the major causes of DRDs, including benzodiazepines, and that clean needles were often not distributed to the target population.

'Should we really be considering 35 as an aging cohort?' he asked, adding 'We believe that cuts have contributed significantly to the stark increase in DRDs.'

'I go to meeting after meeting and nothing happens – in the meantime we bury people,' said his co-author Barry Sheridan. 'It's a depressing picture, but when working in these communities it's heart-rending.'

'We're preaching to the converted here – we need to be reaching some different minds.'

ALEX BOYT

Peter Krykant had become known as the pioneering activist behind Glasgow's mobile overdose prevention facility, set up because a legal facility planned by the health board and council was thwarted. He explained how, over the past eight weeks, he had provided a safe, clean, sterile environment for people to use drugs in a converted minibus. It was equipped with naloxone and defibrillators and the team were trained to provide basic first aid and harm reduction advice.

It offered 'safety from the rat-infested alleyways they currently inject in', he said. As well as instilling safer practice, it had already saved at least one life through administering naloxone. The harm reduction advice was invaluable: there was a high incidence of street benzos (a major contributor to deaths in Scotland) and many people were found to be injecting coke, often when on a high dose of methadone.

A second site was in train – in a pop-up gazebo – using experiences from Copenhagen and Canada, and there were hopes to launch a third site. At the time of talking at the APPG (21 October) the team had experienced no significant intervention from the police 'who had been fantastic', but since the meeting Krykant had been cautioned by police under the Misuse of Drugs Act 1971 (news, page 5) – a situation opposed by many individuals and organisations, including the Scottish Drugs Forum, who called it 'deeply regrettable and unnecessary'.

APPG participants were unanimous in their support for the initiative – including representatives of treatment services, who emphasised that they were constantly reviewing and developing the ways they worked. **DDN**

Responses from treatment providers to the latest DRD statistics, page 18.

nigelbrunsdon.com

GETTING ENGAGED

adventtr/iStock

With drug-related deaths once again hitting record levels, it's never been more urgent to make sure we're properly engaging with so-called 'chaotic clients'. **DDN** reports

'Engagement is always a tough one,' says Dr Bernadette Hard, GP specialist in addictions with Kaleidoscope. 'It's always problem in services, but that's the nature of the disease.'

The gamut of engagement can run from highly motivated clients paying for their own treatment, via self-referrers who achieve good levels of stability but may begin to drift away, through to those who struggle to meet appointments and frequently drop out of treatment – if they engage at all.

Much has been written about so-called 'chaotic clients', and a perennial challenge for services has been finding ways to bring more stability to this group, especially as they feature heavily in drug-related death statistics (see news, page 4). Scotland has long wanted to pilot consumption rooms, which have proved effective in other countries, but legal wrangles with Westminster have made this impossible. The closest anyone has come so far has been the establishment of a 'safe consumption' van in Glasgow, which has made national headlines despite technically operating outside the law.

Heroin-assisted treatment (HAT) – widely accessible in the UK until 1967's Dangerous Drugs Act put paid to it, and available elsewhere in Europe – is showing signs of making a comeback, however, with a pilot programme launching in Scotland late last year (*DDN*, December/January, page 4) and more and more police and crime commissioners coming out in favour of it.

The results from the Glasgow HAT pilot, which has been incorporated into the city's Enhanced Drug Treatment System (EDTS) have been promising, particularly for people who've experienced homelessness or been involved in the criminal justice system (*DDN*, March, page 8). One major benefit of the scheme has been to enable these clients to engage with other services, such as BBV, mental health or housing teams.

A number of trials are also taking place to provide long-acting buprenorphine to chaotic clients, which means people no longer need to make regular trips to the pharmacy to collect medication – or be supervised taking it, something that many find stigmatising and humiliating. Delphi Medical have so far provided around 25 clients with long-acting buprenorphine, starting around ten months ago. 'When we first looked at the product it seemed to be aimed towards more stable groups, but the benefits quickly became apparent for the more chaotic group,' says head of medicines management, Colin Fearns.

It was a similar process at Kaleidoscope, says Hard. 'Initially the general feeling was that it was the obvious choice for people who

'The whole system needs to be broken down and built from the street upwards.'

MICK WEBB

'I was probably the only voice saying let's try it on people who are treatment resistant.'

DR BERNADETTE HARD

'The benefits quickly became apparent for the more chaotic group.'

COLIN FEARNS

were quite stable. I was probably the only voice saying, "Let's try it on people who are treatment resistant". It took more than three months to persuade anyone in the chaotic group to try it, she says. 'Then the first two did OK, but with the third it was outstanding. This was a lady who'd been in and out of services – multiple restarts, prison, sex working, domestic violence, living in a night shelter. She'd been in hospital with ulcers on her legs, with infective endocarditis for her heart valves from the bacteria from injecting, massive self-neglect. She was mentally beaten, completely disengaged, very hostile, very suspicious.

'I had very low expectations,' states Hard. 'But I thought I can't make this worse.' A week after she finally agreed to an injection 'I didn't recognise her', and a year later she remains drug free and is working and looking after her children. 'What she fed back was that having that stable dose turned off the cravings, and combined with that she was able to basically just hunker down.'

Eliminating the need for regular attendance at pharmacies also removes people from potential triggers and from meeting people who might be carrying drugs or who may bully them for their prescription. Unlike sublingual buprenorphine, where it can still be possible to get some effect from heroin, long-acting injections shut this down completely.

Incorporating something like long-acting buprenorphine, however, can often require a fundamental readjustment on the part of both service users and services, explains Fearns. 'From a psychological point of view for the client, the worker and the service as a whole it was alien,' he says. 'It can be really difficult to grasp that someone doesn't want to come into service because they don't feel they have to – because they're well. If you're used to sitting at home, waiting for your drugs, taking drugs, doing nothing, and now all that's suddenly removed you've been launched into recovery, so it's about what you do with your time.'

As Alex Boyt stressed in October's *DDN* (page 8) when it comes to prescriptions the key issue is flexibility. Prescribing needs to be 'massively flexible, but sensible as well', states Mick Webb, coordinator at Community Driven Feedback (CDF) in Bristol. This applies even with something like HAT, he says, with services needing to remember that every prescribing regime should be tailored to individual needs. 'It has to be delivered with the right level of independence – people need to feel that they own what they have.'

Other wider prescribing options could potentially include medicinal cannabis, as recently highlighted by Nick Goldstein (*DDN*, October, page 12). 'Why can't I go to a drug worker and say "I don't want these horribly addictive drugs you've got me on, but smoking weed really helps with coming off them – can you prescribe me medicinal cannabis?"' says Webb. 'They're scared because they don't have the guidelines, but we can help write those guidelines.'

Prescribing regimes need to be based on thorough and extensive research of what people want, which would also be a key way of starting to build trust with populations seen as chaotic, he believes. 'What is there for crack users? Absolutely nothing.' The obvious way to do this is via peers – a 'massively under-used resource, and they're often treated abysmally and won't do anything about it, because they don't know their rights. The people I'd speak to if I had a problem would not be drug workers, it would be my peers who know me well. At the moment the whole system needs to be broken down and built from the street upwards.'

The major part of any drug worker's job should always be about how to empathise and understand, he believes. 'I've seen it from all sides. I'm a service user, I've been a prescriber, I've worked in management. In some ways since COVID it's been a good thing – people on daily supervised consumption suddenly found themselves on weekly, while some people would have preferred to stay on daily because it's the only contact they might have with a health professional. It should always be about the individual.'

And it's the peers who should be training drug workers, he stresses, 'not other people working in the field – because there are certain restrictions and things you can't talk about. With peers there aren't those barriers – you can have some fun with the training and start stimulating that passion again.'

But for now, trust remains lacking, he warns. 'Sadly, for a lot of people the best option is to not have anything to do with services. People aren't prepared to take the risks – they feel drug workers aren't people that you can be honest with. So I think it's about training and employing the very people that they're trying to reach. I don't think there are many other options.

'Start from the street up, just start with a blank canvas,' he says. 'Getting out, doing street work and asking people what's going on. We're here, we're right in front of people. This "hard to reach" expression is worn out. If people are being called hard to reach, they're being made hard to reach.' **DDN**

This article has been produced with support from an educational grant provided by Camurus, which has not influenced the content in any way.

The right CONNECTIONS

The Recovery Connectors group and lived experience recovery organisations (LEROs) are reshaping the way we look at recovery, say **David Best**, **Stuart Green**, **Dave Higham**, **Tim Sampey**, **Tim Leighton**, **Jardine Simpson**, **Michaela Jones**, **Dot Smith** and **Ed Day**

Long before the championing of recovery in the *Drug strategy 2010*, there were incredible efforts across the country – many run on a shoestring – to provide hope, guidance and support for people in recovery, often outside of formal treatment structures. These efforts have been increasingly important as a result of austerity and the reduction in mainstream funding for specialist services, and have been brought more into focus during the COVID pandemic when looking at what community support there is post-treatment.

These organisations and groups have often had to survive on goodwill and sometimes small sub-contracts – vulnerable to being cut if the overall contract fails to deliver, and open to the criticism of lacking formal evidence and credibility through reporting mechanisms such as NDTMS. This is not always the case, yet it provided the impetus for the Recovery Connectors group to form.

Starting in May, a group of ten champions of recovery from different corners of the recovery ecosystem began to meet on a weekly basis to share their thoughts and support each other. An agenda quickly developed consisting of five objectives:

1. *To expand the scope beyond a narrow definition of recovery to include all of those damaged by exclusion and marginalisation – and so the term **LERO** (lived experience recovery organisation) was born*
2. *To provide a platform for sharing and disseminating the **innovations** that are central to recovery-oriented organisations*
3. *To agree on a core set of **values** for lived experience recovery organisations*
4. *To create an **evidence base** for recovery organisations to provide credibility and professionalism*
5. *To develop a set of **standards** for LEROs as a framework for growth and development, rather than a cage.*

MEANINGFUL LIVES

It's no coincidence that these five objectives connect to form another acronym – LIVES. The aim of all LEROs is to support individuals, families and communities to lead positive and meaningful lives that contribute to the wellbeing of their communities. This parallels and builds on our previous work on 'recovery cities' based on the notion of developing community growth and wellbeing. Our early endeavours have seen a recent round table contribution to the Dame Carol Black review and have been highlighted by William White in his blog: *http://www.williamwhitepapers.com/blog/2020/09/networking-uk-recovery-community-organizations-a-2020-progress-report-david-best-and-co-authors.html*

LINKING TO THE NORTHERN RECOVERY COLLEGE

There was a natural fit between the LERO initiative and the Northern Recovery College (*DDN*, April 2019, page 6) which has for the last three years been running events across Yorkshire and Humber as a partnership between the University of Derby, Spectrum, RDaSH (Rotherham, Doncaster and South Humber NHS Trust) and ADS (Alcohol & Drug Service), with the aims of:

- *Educating the alcohol and other drug treatment workforce about recovery*
- *Providing a forum for people in recovery to learn, innovate, share and develop their understanding and knowledge*
- *Generating different experiential learning for the attendees*

The event held on 25 September was the formal launch of the Recovery Connectors group and the LERO initiative, using the Recovery College principles but delivered online. The aim was to explain the logic of the approach and canvas initial opinions and willingness to engage from outside the current group.

> 'The way LEROs have been grassroots, each unique, and each owning their own approaches, has been community-driven and deeply democratic.'

The day started with a panel discussion involving all of the Recovery Connectors, offering a discussion of what the aims of the group are and how we are intending to evolve, and highlighting that LEROs are truly person-centred and asset-based rather than system-centred and deficit-based on health needs assessments.

The remaining three hours were expertly hosted on Zoom by our Canadian colleagues Peter and Yvonne from Axiomnews.com, who ensured that everyone had a chance to express their views and become actively involved. The Axiom News team have been practicing asset-based community development

and appreciative inquiry for two decades, and remarked on the similarities between LEROs and those approaches, such as:

- *Honouring each person and their voice*
- *Openness and generosity*
- *A focus on giftedness*
- *Belief in personal agency and community abundance*

PATH TO RECOVERY

While working with us on the summit, Peter was struck by phrases like, 'we are experiential people' which reflect the potency of lived experience in all of life's recovery and thriving. The way LEROs have been grassroots, each unique, and each owning their own approaches, has been community-driven and deeply democratic. He feels that this way of being offers a path to recovery from dissociation in all of its forms, and that people with lived experience and LEROs offer a beacon and leading light even beyond their own communities. It was an incredible bonus that they captured the event in the poem and sketch shown.

It was a positive and rewarding day for all, and one that clearly indicated the appetite and need for the Recovery Connectors' work and for the LERO initiative to form wider associations and more formal connections. A total of 168 people signed up for the event and throughout the day there were typically around 80-100 people actively participating. The whole event will be shared in the near future.

We have been overwhelmed with messages of support since and, crucially, by requests to be involved. A follow up 90-minute Big Conversation event is planned for 4 December to explore reflections from the initial launch and discuss current and future developments. You can book via *https://recoverycollegesummitreconnect.eventbrite.ca*

SO WHAT NOW FOR LEROS?

Our group will continue to meet on a weekly basis and we are meeting up in November to advance each of our aims around the LIVES agenda. We will start to work on a set of standards for LEROs that are not simply an adaptation of specialist treatment services but that recognise the unique demands and needs of LEROs. We will continue to refine our values and our model for championing innovation and the evidence base.

We will continue to act as one of the working groups for the College of Lived Experience Recovery Organisations and will attempt to increase the profile, professionalism and connectedness for LEROs to influence strength-based commissioning in local areas. We are also looking to continue to engage LEROs from across the UK in our Recovery Connectors Forum. We want you to be a part of this exciting work, to inform and advise us and to help create a unified and coherent voice for LEROs.

We want to unite LEROs, celebrate differences and create an opportunity for these groups to have a voice and remain equitable against more formal care structures in the local communities we serve.

To be a part of the Recovery Connectors Forum, please contact LERO.connectors@gmail.com

LERO POETIC HARVEST

A collection of phrases spoken by participants and presenters on the day

I am a recoverist,
Supporting, representing, connecting

Small local organizations on the periphery
LEROs
Peer-led
A collective voice
No two the same
Each utterly unique and different
Co-designed

Experiential knowledge is a different kind of knowledge
Traditional approaches to society have fallen short
LEROs are an ideal lead

An ecosystem of LEROs
The power of connection

We are experts by experience
I don't want to be fixed, I want to connect

The struggle is real

Co-producers of our own change

It is nice to not be flapping about in Brighton on my own

We are led by the people
We are natural connectors
We are experiential people
We focus on assets

We are not fear led

What struck a chord,
Walking backwards in life....

Somebody believed in us
One person can make such a massive difference

It's not a tick box,
We need maverick commissioners to
Interact in an equitable way,
View people as Citizens

I am struck by the power of storytelling
Connectivity makes us a community of consequence

The opportunity is now

HAVE YOUR SAY
Write to the editor and get it off your chest
claire@cjwellings.com

SUPPLY AND DEMAND

Bill Nelles describes how British Columbia's 'safe supply' scheme is providing oral opiates to at-risk populations

'Safe supply', the provision of pharmaceutical-grade opioids to regular opioid users, is certainly where the rubber meets the road. For many injecting users, it's a critical health issue – but the medical professionals here appear stuck in the familiar argument of 'will it cause benefit or harm?'

The issue is triggering a robust conversation amongst doctors. On one side are older doctors who are strong traditionalists and who believe in conventional oral treatments like methadone and buprenorphine but no further. They allege there is diversion and danger, and feel such prescribing could attract people otherwise doing well on traditional medications.

On the other side are the doctors conducting pilot studies to see if opioid users currently outside of treatment will be attracted to a safe supply of strong oral opioids rather than using the poison that passes for heroin on our streets. The people being recruited are experienced opioid users, not people naïve to opiates, and the participants are the group most at risk of overdose here in British Columbia (BC) – men between 35 and 60 who are not engaged in traditional maintenance treatment.

Safe supply is now official health policy and supposedly prioritised but it's not at all clear that our equivalent of the GMC, the BC College of Physicians, is collaborating with this. Eight years ago the college, shocked by the increasing numbers of opiate-dependent patients with chronic pain, set daily prescribing limits, (since somewhat relaxed) and encouraged family doctors to limit prescribing opiates for three to five days. Around 2010 the BC opiate crisis began first with overdoses from pharmaceutical drugs, but as these became scarcer illicit fentanyl became the dominant supply.

The college has accepted supervised injectable maintenance but the provision of oral opioids is causing more concern. Research and statistics are needed to find what is really happening, and these are being gathered. However, enquiries made with the BC Coroners Service indicate no corresponding increase in deaths due to prescribed opioids since these pilots started.

And the really good news is that our left-of-centre pro-reform party recently won a large majority in our provincial elections. This bodes well for progressive health policies. With Scotland leading the Euro league table for overdose deaths, and Portugal second to bottom, I know which direction I want my province to take. I just wish my beloved UK would follow suit.

Bill Nelles is an advocate and activist, now in Canada. He founded the (Methadone) Alliance in the UK

'There is no such thing as 'medical marijuana'. To use the term is not only wrong but dangerous as it refers to the whole drug, consisting of hundreds of different compounds.'

CANNABIS DANGER

In response to Nick Goldstein's article (*DDN*, October, page 12), there is no such thing as 'medical marijuana'. To use the term is not only wrong but dangerous as it refers to the whole drug, consisting of hundreds of different compounds. However two of the extracts of cannabis, THC and CBD, purified and having undergone mandatory clinical testing, have been passed for medical use.

THC in the synthetic form of nabilone (Dronabinol, Cesamet, Marinol, Syndros) increases the appetite of cancer patients, is an anti-emetic and a sleep apnoea reliever. It is also effective for HIV/AIDS induced anorexia and chemotherapy-induced nausea and vomiting only. CBD as Epidiolex is used for two types of severe epilepsy.

Professor David Nutt is quoted – why? He is a self-confessed pro-legaliser and was sacked from the ACMD for his views.

The whole truth of the harms of cannabis use is still not publicised fully. It has been proved to cause psychosis, brain damage, cancers, dependence and addiction. It adversely affects the immune, heart and reproductive systems. It causes depression, aggression, violence, suicides, respiratory and cognitive problems.

Today's cannabis is many times stronger than that used in the past. It is a truly dangerous drug.

Mary Brett, chair, Cannabis Skunk Sense (CanSS, www.cannabisskunksense.co.uk)

BACK TO FRONT

It's so goddamn backwards and behind. 'Fistful of lethal opiates please doc?' Yeah sure, no problem. 'Medical marijuana prescription please for this agonising pain that keeps me from my family and awake at night?' Absolutely not, it's junk for druggies.

Kelly-Marie Nettleton, DDN Facebook page

DDN welcomes all your comments. Please email the editor, **claire@cjwellings.com**, join any of the conversations on our Facebook page, or send letters to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Longer comments and letters may be edited for space or clarity.

/ddnmagazine
@ddnmagazine
www.drinkanddrugsnews.com

Turning Point Smithfield In-Patient Detox

Has Covid pushed you over the line?

If you are in need of a break and help with your alcohol use, we can look after you. We offer 7-day stays at our Smithfield Detox service in Manchester. All our services in the local area are integrated, including Rehab Residential Stay and Supported Living, so you can get any further help you need.

Book your stay now on **0161 827 8570** or **smithfield.admissions@turning-point.co.uk**

Visit our website at **mytp.me/detox**

TURNING POINT
inspired by possibility

No time to lose

We've reached a critical point with drug-related deaths. Here are five things we all must do better, says **Karen Tyrell**

I was a drug worker myself 20 years ago and the ever-inflating drug-related deaths total still makes me feel sick at heart.

The latest figures show another desperately sad increase. We get into this sector because we care. These are people we did our best for and who were cared for by their family and friends. We know they're not just numbers on a spreadsheet somewhere.

But the reality is that local alcohol and drug services are operating under immense pressure as our funding continues to decrease. And given that we are in a world which also has a pandemic, it doesn't feel hopeful that this is going to change quickly.

Indeed, the dissolution of Public Health England, too, makes it feel like we have now come to a critical point. We are waiting to hear the outcome of the second stage of the Dame Carol Black review – but the spending review has been shelved

'The time for an overhaul of current drug laws, which are outdated and not evidence based, is long overdue. Services also need to be adequately resourced, but not in isolation. Substance misuse, social inequality, and poor health – mental and physical – are all connected.'

Use the evidence

The time for an overhaul of current drug laws, which are outdated and not evidence based, is long overdue.

Services also need to be adequately resourced, but not in isolation. Substance misuse, social inequality, and poor health – mental and physical – are all connected. Over the last decade the death rate has been significantly higher in deprived areas.

Services across different sectors of health and social care should be provided with the resources and autonomy to break down arbitrary and harmful divisions, especially those between substance misuse and mental health services. This will reduce stigma and allow passionate frontline workers to focus on people instead of processes.

We are at a crucial tipping point. Without a change in direction and without evidence-based approaches, deaths will continue to increase.

Mark Moody, chief executive, Change Grow Live

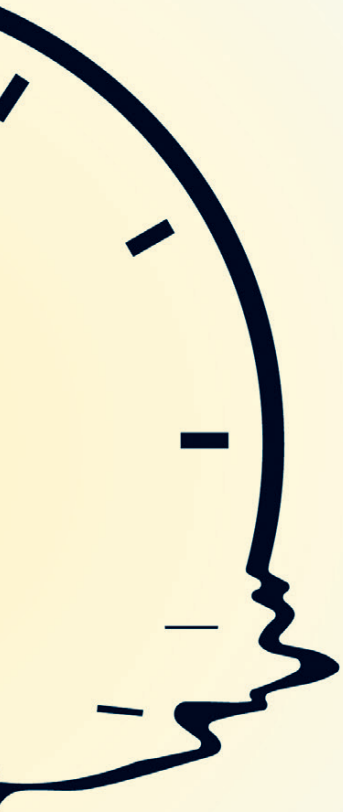
Change the law

In the last 12 months, two parliamentary select committees – the Health and Social Care Select Committee and the Scottish Affairs Select Committee – have called for drug policy reform in the UK in order to tackle drug-related deaths, citing the need for investment in treatment and harm reduction, supporting calls for overdose prevention sites and calling for a review of the law to end criminal sanctions for possession offences.

If the home secretary and the prime minister continue to ignore these calls, then they will continue to be responsible for the deaths of thousands of people every year. It is time to stop playing politics and listen to the evidence.

Drug deaths are not inevitable. This public health crisis will not abate unless we scale up harm reduction initiatives and pursue policies based on science and evidence rather than ideology and moralism.

Niamh Eastwood, executive director, Release



by government, so it may be some time before we see any change in terms of improved funding.

Which leaves it up to us, as a sector, to step up.

> 'Our services and the infrastructure of a once-good treatment system are more than frayed at the edges; they are beginning to fall apart.'

There are a few things I think we can all do better. We need to go back to basics and get the fundamentals right. This could save lives, help improve capacity in the system, and help more people to move forward with their lives and regain good health:

1. **FOCUS ON OUR HARM REDUCTION SERVICES**, keep them open and get them right. We need to deliver great harm reduction advice, including overdose prevention, and offer a broad range of needle and syringe provision. These services need to be easy to get, consistently available and low threshold.

2. **GET NALOXONE OUT TO AS MANY PEOPLE AS POSSIBLE.** Treat it as a normal part of how treatment starts, not an optional add-on. Make sure it is everywhere.

3. **MAKE SURE WE ALL PROVIDE A GOOD RANGE OF ONLINE GROUPS** which are easy to access for as many people as need them. Yes, I know not everyone has a computer – but they've been a lifeline to many and are an opportunity for us to build a new way of providing a wider range of support to more people.

4. **FLEX OUR APPROACH TO PRESCRIBED MEDICATION** where we can to make it easier for people to stay in treatment. This means being careful, but also being brave.

5. **BUILD ON THE WORK WE SAW HAPPEN IN LOCKDOWN**, bringing communities together. This means helping people to see a bright future with opportunities to connect, and rebuilding their lives with meaning. There was a lot of creativity and partnership working in local services and communities – let's grow that with our commissioners and partners.

Our services and the infrastructure of a once-good treatment system are more than frayed at the edges; they are beginning to fall apart. So it's time to not just make do, but mend. We can still do it by returning to the basics of a good system, being creative and using smart, new technology to reach more people in more areas.

The drug-related deaths figure always gives us pause for thought. We all have an opportunity for change.

Karen Tyrell is an executive director at Humankind

Level up

Behind most deaths are stories of trauma and people doing their best to cope with emotional pain that has never been resolved. We know that people who use drugs problematically but aren't in treatment are most likely to die of a drug-related cause.

It's also clear that cocaine use has increased exponentially in the last decade, with both crack and powder becoming increasingly available and affordable, yet many people remain unaware of the potential harms. We need much better education early on in schools and throughout the population on how to use drugs in the safest way possible and what support is out there.

We also need to recognise that problematic drug use is often a reaction to people's surroundings. Issues such as rising homelessness, poor mental health and a lack of economic opportunities in some areas all lead to people using drugs. It's therefore no surprise that drug-related deaths are highest in the UK's most deprived areas, with the impact of the COVID-19 crisis likely to exacerbate many of these issues. It's more important than ever that the government stays true to its levelling up agenda to address inequalities across the country.

Laura Bunt, deputy CEO, We Are With You

Invest in treatment

There is indisputable evidence that treatment saves lives and it's time for action to provide the investment that can reverse this tragic loss of human life.

These statistics show that almost half of deaths are related to opiates. Long-term heroin users with poor health, who frequently engage in poly-drug and alcohol use, are most at risk. For this group the best way to prevent drug-related deaths is to get people into treatment.

Widescale distribution of naloxone kits, which can be used to save someone's life if they overdose from heroin or other opioids, is also key to preventing deaths. We have been delivering training to community pharmacies to deliver take-home naloxone services to make it even more accessible.

Graham Parsons, chief pharmacist, Turning Point

Equal opportunities

In the last decade, rates of drug poisoning deaths have been higher in the most deprived areas of England and Wales.

Targeted investment in all forms of treatment could create fair and equal access to treatment.

Everyone should be able to access good quality healthcare regardless of wealth. The stigma of addiction leads of discrimination, exclusion from healthcare and the tragic loss of life. It is evidently wrong that the people with the most complex needs, and fewest resources, should have to fight the hardest, overcome the greatest barriers, and contribute the most financially, to access healthcare.

Karen Biggs, chief executive, Phoenix Futures

A PLATFORM FOR RECOVERY

Liam Ward describes how Phoenix Futures Scotland has joined forces with ScotRail to boost residents' recovery and transform local railway stations at the same time

Phoenix Futures Scotland and ScotRail have been working together over the last year to enable people in residential treatment to participate in the ScotRail 'adopt a station' volunteering programme. Since the programme launched in 2005 Scotland has seen the rejuvenation of over 260 railway stations through arts projects, charity initiatives and horticultural displays by community volunteers. Historically many stations in Scotland were known for their garden areas and this programme has seen a resurgence of pride among communities for their local station.

Before the nationwide lockdown the Phoenix Futures Scottish Residential Service 'adopted' Anniesland Station, meeting with Tracy Stevenson, the ScotRail community team's development assistant, to discuss their plans for a range of activities. The residents then set about making these a reality by researching the types of plants that would be suitable in a station environment, sourcing materials from suppliers and creating a calendar of activities.

During lockdown Phoenix's residents were unable to visit the station, so they began to grow seeds and bulbs in the residential's own garden space that they will transfer to the station later. Following the relaxation of restrictions they were able to return to Anniesland station in September, with some additional safety measures in place. The majority of work so far has been identifying and preparing the areas they will be working in, and making them habitable for plant life. They have been receiving great feedback from station staff and local residents, and this has given everyone a sense of acceptance into the community.

The plans involve planting trees and flowers to promote a biodiverse environment and provide natural habitats for insects and wildlife, using recycled materials wherever possible. Some of the more eye-catching designs are train planters created by residents at HMP Glenochil, with a plan in place to turn them into carbon capture gardens – Anniesland will be one of first locations to have these planters installed.

Among the many benefits of this programme and partnership are enabling people accessing Phoenix Scotland's services the opportunity to learn about the environment and develop new skills, as well as the therapeutic effects of being outdoors. It also provides the opportunity to support local communities and break down stigma.

By adopting Anniesland station Phoenix will deliver its Recovery through Nature (RtN) programme practically on its own doorstep, as the station is a five-minute walk away. While RtN has been a core part of the treatment programme for a long time, the adopt a station initiative has meant improved accessibility to RtN, including for wheelchair users. Phoenix has also agreed to adopt Dunfermline Town railway station in Fife, where it already delivers RtN programmes (*DDN*, July/August 2019, page 17) and Communities of Recovery peer mentor services, and over the next few months service users will be clearing sites and installing carbon-capture gardens.

'I am delighted to welcome Phoenix Futures Scotland to the adopt a station volunteering programme,' said Tracy Stevenson. 'At ScotRail, we're committed to supporting the communities we serve, and everyone in them. Through this partnership we aim to support and encourage people within the community who are recovering from addiction. Our adopt a station programme is an inclusive environment where Phoenix residents can actively participate in their own community while learning new skills and increasing their confidence. This will help support their lifelong commitment to recovery.'

At Phoenix we enjoy getting involved in the communities in which we live, and actively look for opportunities to develop our local community work. ScotRail has given us a great opportunity to do this.

Liam Ward is residential marketing manager at Phoenix Futures

DrinkCoach App

Free to Download • GDPR Compliant

The free DrinkCoach app is a useful tool for service users and also supports the work that recovery workers do. Check out how:

Drink Diary

- Service users can share their drink diary summaries with their recovery worker directly from the app

Goal Setting

- Service users can transfer their agreed drinking goals into the app and get feedback on their progress

Location-based reminders

- Service users can input high risk locations or venues and receive an alert with a reminder note

Time based reminders

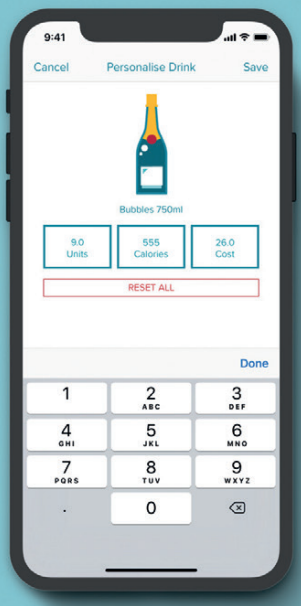
- Service users can create unlimited reminder notes for high risk days/times

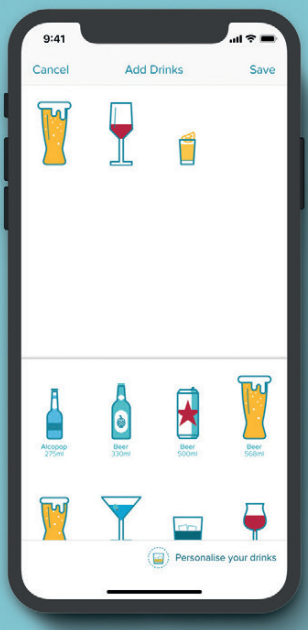
Events

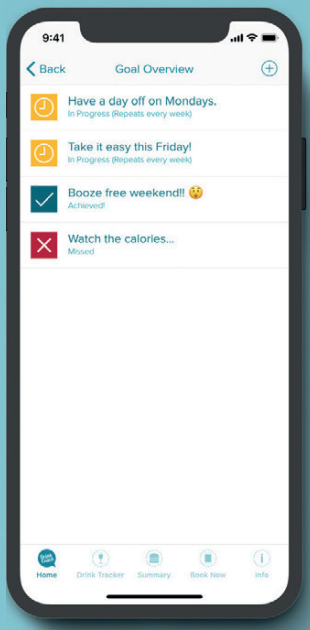
- Service users can log the impact of their drinking with the events diary to help build awareness and motivation to change

Urge Surfing

- Service users can manage their cravings with urge surfing videos







[Free to download and use on Android and iOS]

drinkcoach.org.uk

Download on the App Store

GET IT ON Google Play

DrinkCoach is delivered by
Humankind Reg charity: 515755
Ltd company: 1820492

humankind®

Change
Grow
Live

Is your organisation working to tackle blood borne viruses?

Our toolkit can help.

Coronavirus has changed our approach to blood borne virus (BBV) testing and treatment. We've put together a toolkit to help make sure everyone gets the testing and treatment they deserve.

In the toolkit you'll find guidance and resources to help your services prioritise and carry out testing safely and effectively in these challenging times.

It's free and available for anyone to download, just visit www.changegrowlive.org and search 'blood borne virus' to explore the toolkit for yourself.

Change Grow Live Registered Office: 3rd Floor, Tower Point, 44 North Road, Brighton BN1 1YR. Registered Charity Number 1079327 (England and Wales) and SC039861 (Scotland). Company Registration Number 3861209 (England and Wales).