

DRINK AND DRUGS NEWS

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DDN

CAPITAL IDEA

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'We need to challenge the narrative on homelessness'

The rising rate of homelessness in this country is a scandal that shames our society. Furthermore, we are passive to the theory that through wrong choices, drugs and alcohol, those on the streets nominate their fate as they become consigned to an invisible underclass that will die a third of a lifetime sooner than they should.

We need, as Alex Stevens says (page 16), to challenge the narrative and acknowledge the moral bankruptcy involved. Crucially, we must do more to bring evidence to daily practice through simple, cost-effective harm reduction, early interventions, and the confidence to reach out and create strong peer networks. Turning our backs on this situation and leaving it to others is not an option – we have the knowledge and the networks to disseminate better practice and ensure that people like Jo (who brought her experience to the recent conference on homelessness) do not fall through the gaps.

An important part of the story is the case studies provided by experts by experience/patients/service users. Their feedback is our gain in improving services, and they should be equal partners in consultation. Our cover story combines service user involvement with innovation and shows what can be achieved as an exciting idea takes hold.

This month we're looking forward to seeing you at our annual conference, where we'll be hosting a debate on the future shape of service user involvement. Let's embrace the opportunity to create a national network that has a clear and informed voice and strikes at the heart of where it's most needed.

Claire Brown, editor

Conference details and booking at www.drinkanddrugsnews.com
Keep in touch @DDNmagazine



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HUGE INCREASE IN 'COUNTY LINES' ACTIVITY, SAYS NCA

'COUNTY LINES' DRUG DEALING NETWORKS ARE CONTINUING TO EXPAND with increasing exploitation of children and vulnerable adults, says a report from the National Crime Agency (NCA).

The county lines model involves gangs and criminal networks moving drugs – primarily heroin and crack – into new supply areas such as smaller towns and rural areas, and using dedicated mobile phone lines to take orders. There are now around 2,000 operative mobile lines compared to 720 in 2017-18, says NCA's latest *County lines drug supply, vulnerability and harm* document, with the gangs remaining 'highly adaptable in their operating methods and practices'.

Gangs will offer free drugs in exchange for contact details of potential customers to expand their supply base, says the report, using 'mass marketing text messages' to advertise their product. Children aged 15-17 – both male and female – make up the bulk of vulnerable people involved, recruited via grooming techniques 'similar to what has been seen in child sexual exploitation and abuse'.

Rather than seeing themselves as victims, the young people are often 'flattered by the attention and gifts they receive', making them less likely to engage with the police. However, the exploitation methods used include sexual abuse, modern slavery, and the 'threat of violence and injury to ensure compliance'.

County lines gangs will also 'capitalise on drug users who allow the use of their property, as well as those who introduce new customers to suppliers in exchange for drugs', says the document. 'These drug users may believe the arrangement to be mutually beneficial, but in many cases will be building up a debt to the offending network, which they are expected to pay back through engagement in county lines offending.'

Government, law enforcement, charities and other organisations need to work together to 'safeguard the vulnerable', the report stresses, with county lines activity driving a two-thirds increase in the number of minors referred as potential victims of modern slavery between 2016 and 2017 (DDN, April 2018, page 4). One

week of coordinated police activity between 21 and 27 January this year saw 600 arrests, says NCA, along with more than 400 vulnerable adults and 600 children 'engaged for safeguarding purposes' and seizures of more than 140 weapons including guns, machetes and swords.

'We know that criminal networks use high levels of violence, exploitation and abuse to ensure compliance from the vulnerable people they employ to do the day-to-day drug supply activity,' said NCA's director of investigations, Nikki Holland. 'Every organised crime group trafficking drugs is a business which relies on cash flow. County lines is no different. What we will continue to do with our law enforcement partners is disrupt their activity and take away their assets. We also need to ensure that those exploited are safeguarded and understand the consequences of their involvement. This is not something law enforcement can tackle alone – the need to work together to disrupt this activity and safeguard vulnerable victims must be the priority for everyone.'

Report at www.nationalcrimeagency.gov.uk



'This is not something law enforcement can tackle alone...'

NIKKI HOLLAND

NO CHARGE

UPDATED GOVERNMENT GUIDANCE on implementing health charging regulations for overseas visitors has clarified the position on drug and alcohol services. These can be considered the equivalent of primary medical services, says the revised DHSC document, which means that they are exempt from any charges to foreign nationals – previous versions had been unclear on which services were considered equivalent. Inpatient care, however – which includes residential rehab – is not considered a primary medical service and will therefore not be available without charge. 'The change will enable drug and alcohol services to provide treatment to anyone who needs it, irrespective of who they are and where they come from,' said Blenheim CEO John Jolly. *Guidance on implementing the overseas visitor charging regulations at www.gov.uk*

'Drug and alcohol services can continue to provide treatment to anyone who needs it, irrespective of who they are and where they come from.'

EU WINE LAKE

EU HOUSEHOLDS spent more than EUR 350bn on alcohol in 2017, equivalent to just under 1 per cent of EU GDP. 'It should be noted that this does not include alcoholic beverages paid for in restaurants and hotels,' says the EU statistics office, Eurostat. The Baltic states of Estonia, Latvia and Lithuania spent the most on alcohol, while Spain spent the least. *Figures at ec.europa.eu*

DAMNING FIGURES

THERE WERE ALMOST 600 DEATHS of homeless people in England and Wales in 2017, according to ONS figures, an increase of almost a quarter over five years. Men accounted for 84 per cent of the deaths, with more than 30 per cent the result of drug poisoning, primarily opiates – a 51 per cent increase over the same period. Separate research by Crisis estimates that there are 12,300 people sleeping rough on the street and almost 12,000 sleeping in tents, cars or on public transport. The numbers are more than double official figures, which are based on local authority estimates or street counts. *Deaths of homeless people in England and Wales: 2013 to 2017 at www.ons.gov.uk; Rough sleeping figures at www.crisis.org.uk*

COMMISSION CALL

THE GAMBLING COMMISSION is consulting on a new three-year strategy to reduce gambling harms. The aim is to 'focus on the range of harms gambling can inflict, particularly those harms that affect those other than the gambler' – such as health, crime and household debt. *Have your say at www.surveymonkey.co.uk/r/J5QR6MT*

STALLED STATE

THE NUMBER OF COUNTRIES PROVIDING HARM REDUCTION initiatives has stalled in the last two years, according to Harm Reduction International's (HRI) latest *Global state of harm reduction* report. Despite injecting drug use being present in almost 180 countries, the number providing needle and syringe programmes has fallen from 90 in 2016 to 86. Funding for harm reduction in low- and middle-income countries is just 13 per cent of what is needed annually for an 'effective HIV response among people who inject drugs', says HRI. 'The lack of progress in implementing harm reduction measures is a major concern and stunting progress in global health,' said HRI's public health and social policy lead, Katie Stone. 'It is disgraceful that governments continue to ignore the evidence in favour of demonising people who use drugs.' *Report at www.hri.global*



FOCUS ON ALCOHOL FOR NEW LONG-TERM NHS PLAN

ALCOHOL CARE TEAMS WILL OFFER SUPPORT TO ALCOHOL-DEPENDENT PATIENTS IN MORE HOSPITALS, as part of the new *NHS long-term plan*. The teams will be rolled out in hospitals with the highest number of alcohol-related admissions to provide help to patients and their families, with the service to be made available in the '25 per cent worst affected parts of the country'.

Alcohol care teams in hospitals in Bolton, Salford, Nottingham, Liverpool, Portsmouth and London have already led to a reduction in A&E attendances and readmissions, says the NHS, while ambulance call outs have also 'significantly reduced'. The new teams will work in as many as 50 settings across the country, delivering alcohol checks and providing rapid access to counselling and medically assisted help to give up alcohol and support to stay off it. Although hospital-based, the teams will work with local community services to 'ensure all needs, including any other health needs, are met'.

Alcohol-related hospital admissions have increased by 17 per cent over the course of a decade, to 337,000 in 2016-17. NHS England estimates the annual cost of alcohol-related harm at £3.5bn. The initiative is part of a major focus on prevention in the new NHS plan, alongside support for patients who smoke and action on obesity and diabetes.

'Drinking to excess can destroy families, with the NHS too often left to pick up the pieces,' said NHS England chief executive Simon Stevens. 'Alcohol and tobacco addiction remain two of the biggest causes of ill health and early death, and the right support can save lives. The NHS long-term plan delivers a sea change in care for a range of major conditions like cancer, mental ill health and heart disease, as well as stepping up to do more on preventing ill health in the first place by giving patients

the support they need to take greater control of their own health and stay fitter longer.'

The focus on managing alcohol-related ill health was 'very welcome', said Royal College of Physicians president Andrew Goddard. 'It is an increasing problem in our hospitals where many patients first come to the attention of the NHS. We mustn't forget prevention though and further measures to reduce harmful drinking are much needed.'

Meanwhile, alcohol-related deaths in Northern Ireland have reached their highest ever level after four years of consecutive increases, according to the Northern Ireland Statistics and Research Agency (NISRA). More than 300 deaths were the result of alcohol-related causes in 2017, a 70 per cent increase since records began in 2001. There were 'notably higher' numbers of alcohol-related deaths in areas of deprivation, said NISRA.

www.longtermplan.nhs.uk
Alcohol related deaths registered in Northern Ireland, 2007-2017 at www.nisra.gov.uk



'The NHS is too often left to pick up the pieces.'

SIMON STEVENS

ZERO TOLERANCE

SCOTLAND IS TO INTRODUCE A 'ZERO TOLERANCE' APPROACH to drug driving from October. There will no longer be any requirement to prove someone was driving 'in an impaired manner', the Scottish Government states, with limits for eight of the most common illicit drugs set a level 'where any claims of accidental exposure can be ruled out'. Drugs associated with medical use, meanwhile, will have limits based on impairment and risk to road safety. 'Drug driving is completely unacceptable, and we will continue to use all of the tools at our disposal to prevent the avoidable deaths and damage caused by those who drive under the influence of drugs,' said justice secretary Humza Yousaf. 'Together with our stringent drink-driving limits, these new laws will ensure that Scotland has the UK's most robust laws against impaired and unsafe driving.'



'New laws will ensure that Scotland has the UK's most robust laws.'

HUMZA YOUSAF.

HUMAN TOUCH

BLenheim CDP AND HEALTH AND SOCIAL CARE CHARITY HUMANKIND have confirmed that the two organisations will merge in April. The new organisation, which will be called Humankind, will employ more than 1,100 staff, offer a comprehensive range of services including housing and health, and work in partnership with providers across the health and social care spectrum. 'Blenheim's passion and belief in people's capacity to change has been at the heart of the organisation for the last 55 years, driving delivery of excellent services and effective campaigning for best practice,' said chair of Blenheim's board of trustees, Eric Feltin. 'By coming together, our joint organisation will have much greater reach to deliver this best practice and have the resources to drive further innovation, developing more compelling services as a result.'

CHEMSEX SUPPORT

A FREE RESOURCE FOR FAMILIES, partners and friends of LGBT people using drugs, alcohol or engaging in chemsex has been produced by Adfam and London Friend. 'Supporting a friend, partner, or family member affected by problematic alcohol or drug use can be difficult,' says Adfam. 'Although family support groups exist, they are not generally LGBT specific, and people attending may not feel comfortable talking about a same-sex partner, or about sensitive issues such as chemsex.' *Chemsex: more than just sex & drugs at adfam.org.uk*



COST COMPARISON

NEEDLE AND SYRINGE PROGRAMMES (NSPs) are a 'highly cost-effective' way of preventing hepatitis C transmission, according to research by the University of Bristol and the London School of Hygiene and Tropical Medicine. With more than 90 per cent of new HCV infections acquired through injecting drugs, NSPs could save 'million of pounds in treatment costs in the UK', say researchers. NSPs 'not only reduce the number of new HCV infections among people who inject drugs and improve their quality of life, they are also low-cost, excellent value for money and, in some areas, save money, which is good news for our cash-strapped local authorities,' said co-lead author Dr Zoe Ward. *Report at www.onlinelibrary.wiley.com/doi/10.1111/add.14519*

USER INVOLVEMENT

Capital idea

WDP's Capital Card scheme has been helping to incentivise and empower service users, the team tells **DDN**

People who come into drug and alcohol services looking for support and treatment are very often also experiencing profound isolation from their communities. Not only can this be damaging to their recovery, it can also have a negative impact on their general health and wellbeing. Helping service users reconnect with the world is a vital issue for substance misuse services.

With this in mind, WDP has launched a simple earn/spend points system that supports service users to make sustainable and significant changes. Created by WDP's joint CEO, Manish Nanda, the Capital Card aims to transform the lives of service users and their families by protecting against social isolation and encouraging people towards proactive and positive engagement at their service.

Much like a retail loyalty card, Capital Card users earn points as they go. When they begin treatment with WDP they are given their own personal Capital Card, and each time they attend a keywork appointment or take part in a group or recovery-related activity they earn ten Capital Card points. They can then redeem the points they've accrued at 'spend partners' in their local communities. These recovery-focused opportunities are diverse and growing, and include gym passes, restaurants, cinema tickets and adult learning. These benefits and experiences inspire people to engage with their local communities, as well as bolstering their recovery.

The idea of Capital Card was initially conceived while trying to improve the engagement we had with our prison-releases – an arrangement was made with a local barber to provide free appointments for a haircut and shave on their day of

The Capital Card, January 2019:

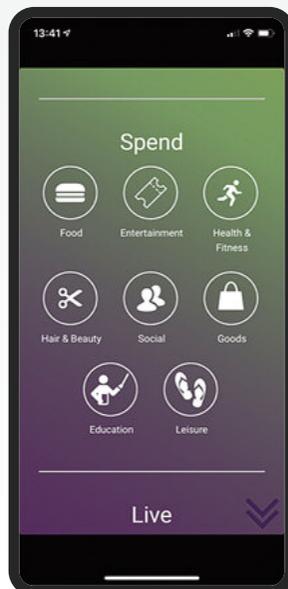
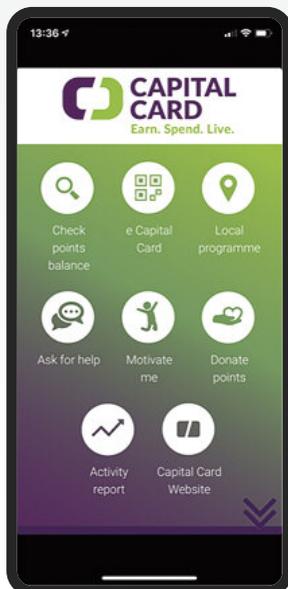
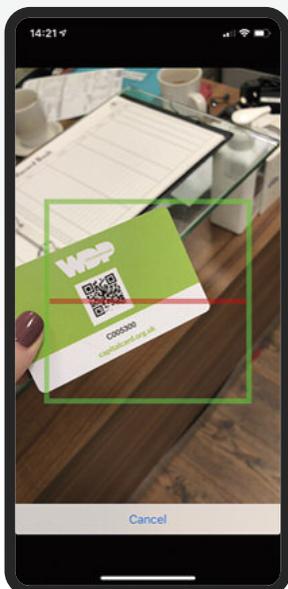
- **3,880+** active service users signed up
- **673,980+** points earned
- **86,780+** points spent
- **25** spend partners
- **40+** different spend activities

release. This proved popular, as service users often like to have something tangible to incentivise and reward their treatment milestones. Manish Nanda, joint CEO, and who was key in its development, said that 'by developing more links with other local businesses, service users would have access to opportunities that they may have previously felt excluded from. After all, everyone likes something for free so why shouldn't our service users get something extra from coming into treatment?'

The card has been designed based on the principles associated with 'contingency management', an evidence-based treatment intervention endorsed by the National Institute for Health and Clinical Excellence (NICE) and which suggests that positive behaviour change is strengthened through reinforcement, reward and recognition. It has also been mapped against the 'five ways to wellbeing' and all spend rewards are focused on supporting service users to achieve healthier lifestyles. The evidence suggests that even a small improvement in wellbeing can help people to flourish.

Points are awarded in real-time, allowing service users to make the immediate connection between their motivation and the incentives for their positive behaviour. There is also a companion app that acts as an e-card where users can check their points balance and see which spend partners are available in their area.

The Capital Card was shortlisted by the Global Good Awards and the Charity Times Awards, and was also named 'digital innovation of the year' at the 2018 Third Sector Awards. 'Winning the digital innovation category at the Third Sector awards is truly a testament to the cutting-edge technology that we are continuously developing as well as the incredible hard work and passion of our Capital Card team,' said WDP chair Yasmin Batliwala. 'It also clearly demonstrates that our service users are at the very heart of all we do.'





After its launch in Hackney in April 2017, the card has been rolled out in the boroughs of Barking and Dagenham, Barnet, Brent, City of London, Harrow, Havering and Redbridge. The scheme will be also be available in the London Borough of Merton and in Cheshire West and Chester from April 2019.

While the scheme and technology are national, the card can easily be adapted locally to meet the needs of each service and its clients. Some services have used it to help meet their KPIs or to incentivise particular groups of service users by setting up 'bonus' structures – for example, by providing bonus points to those who complete a full course of BBV vaccinations within six months.

Having such a flexible scheme means that each service can benefit from national spend partner opportunities while also having smaller local independent businesses involved. Most Capital Card spend partners are charitable or corporate social responsibility-minded organisations that want to give something back and reward those trying to help themselves during a difficult period in their lives.

WDP services also run monthly in-house Capital Card pop-up shops, which have donations from local spend partners and community members. These allow service users to 'purchase' goods such as clothing, essentials, toiletries and books that they may not otherwise be able to afford in exchange for points. 'I think the Capital Card pop-up shop is absolutely wonderful,' said one cardholder. 'I think it is a very good place to get some toiletries and helps a lot – it's given me a boost. This morning I was strongly grieving over my daughter and I am feeling good now.'

Service user involvement is central to the Capital Card enterprise. Service users have enthusiastically supported the production and evolution of the card from the beginning and provide regular feedback on what's working well and what needs improvement, as well as the type of spend partners and incentives that they want to see.

There have also been spend opportunities organised for more isolated service users so that they can attend group activities with their peers. One good example is locally organised Nando's outings. These have had excellent feedback, with service users describing how they allow them to socialise, avoid isolation and feel safe in an accepting environment, while enjoying a meal that they wouldn't otherwise be able to afford.

'One of the key reasons for Havering Council awarding the adult drugs treatment service to WDP was its commitment and drive to innovate in the sector,' said senior commissioning manager at the London Borough of Havering, Daren Mulley. The Capital Card is not only local authority-endorsed but was also singled out in a positive Care Quality Commission (CQC) report for WDP's Harrow service in 2018, where it was described as an area of 'outstanding practice' for service users. The next step is now looking at the card's impact in more detail. With more than 12 months of data from its Hackney Recovery Service, WDP is working with London South Bank University (LSBU) to analyse and publish the statistical impact.

'We compared treatment completion rates in Hackney over a two-year period, before and after the introduction of the Capital Card,' said professor of addictive behaviour science at LSBU, Antony Moss. 'Once we controlled for some differences between these two time periods in terms of client demographics – age, sex, and primary substance – our analysis showed that the Capital Card was associated with



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a 50 per cent increased likelihood of clients successfully completing treatment. These results are very encouraging and justify further evaluation of the Capital Card in a definitive trial.'

'Our belief that recovery cannot be achieved behind just the four walls of a treatment agency has really fuelled this simple yet powerful home-grown innovation,' said Arun Dhandayudham, joint CEO. 'The early findings from the LSBU analysis are incredibly encouraging, and combined with service user feedback, strengthens our belief that those who have access to the Capital Card can achieve improved recovery outcomes as well as reconnecting with their local community.'

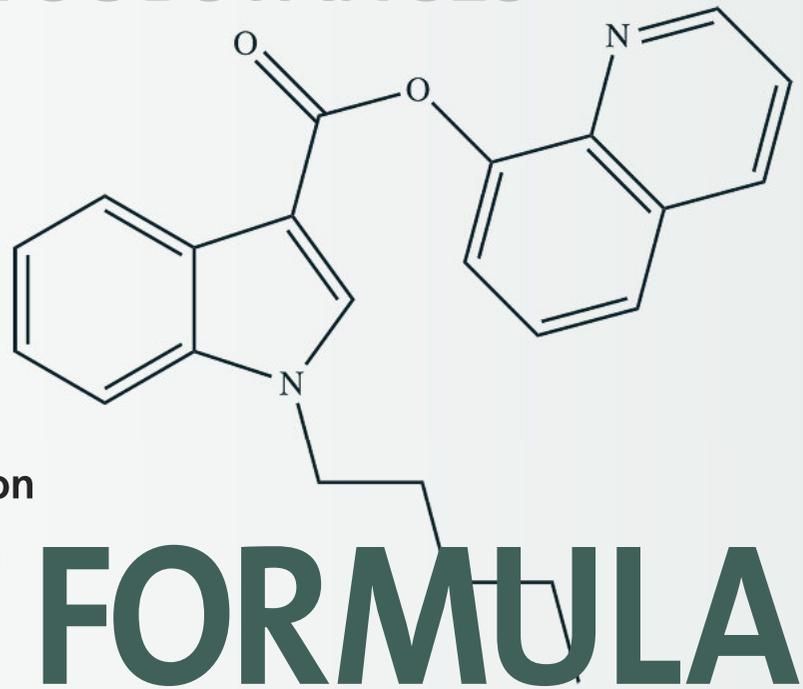
www.capitalcard.org.uk.

If you are interested in setting up the Capital Card in your area, contact Holly Price, capital card manager on holly.price@wdp.org.uk or 07557 393 980.

NEW PSYCHOACTIVE SUBSTANCES

Effective formulation – properly understanding a service user’s life experience and wider contributory factors – is essential to helping people struggling with NPS problems, say

Dr Stephen Donaldson and Lauren Dowson



THE RIGHT FORMULA

Recent research suggests that the use of new psychoactive substances (NPS) including synthetic cannabinoid receptor agonists (SCRAs) has been relatively low among adults (Home Office, 2016). However, younger people – and younger men specifically – appear to be those most likely to use these substances.

Differing potency, toxicity and chemical structure of SCRAs mean that the individual effects vary, but there is consistent agreement from service user accounts and guidance documents (*Manchester health and care commissioning*) that hallucinations and transient psychotic experiences are common. Understandably, these experiences can be extremely frightening, with anxiety and panic attacks being common side effects. While these symptoms are usually short lasting, for some regular and heavy users they can persist and may lead to contact with crisis services and, in some cases, inpatient admission.

Cannabinoid NPS users are usually brought to the attention of crisis mental health services by the local police, in response to concerns from family or the general public about their immediate safety. This is due to anxiety around the individual’s risk to self or others, and this presentation requires clinicians to quickly contemplate how to manage conflicting aspects of an assessment.

This means taking into account management of the care and safety of the service user, pressures on police staff and concerns of family members or carers, at the same time as assessing mental health and the possible need for intervention. This immediate, solution-focused response means that it can be difficult for a clinician to work in a more preventive manner, for example by prioritising the formulation of the service user, taking into account the precipitating factors of this or other novel psychoactive substances.

Admission to psychiatric care can also be an extremely difficult and worrying experience for any service user and their family. However, for those where spice use is a precipitating factor, the rapid onset of unusual experiences, hallucinations and emotional dysregulation appear to significantly add to the psychological distress of all involved. During admission, and once in a period of stabilisation, there can also be an experience of ‘secondary distress’, as service users

gain insight into how unwell and at risk they were prior to coming into hospital.

While mental health services are developing new skills in the management and treatment of cannabinoids and other NPS, gaps in research, knowledge and training remain. As a result it has often been difficult for services to know how best to move forward.

As part of an organisational approach to understanding service users’ needs, acute services in Scarborough (both crisis team and inpatient services) use formulation alongside the service user to promote recovery. The development of a person-centred formulation is a collaborative approach, where the service user, their family and the professionals involved in the individual’s care work together to hear and understand the service user’s story. This purposeful formulation approach has the ambition of thinking about the individual’s presenting difficulties and use of cannabinoids and other NPS substances in the context of life events which were likely to have made the individual more vulnerable.

This approach helps to ensure that the multi-disciplinary team doesn’t hold a single story of the service user which may see their use of NPS as the sole problem. This approach also helps to develop a collaborative co-produced understanding of the individual’s needs in the context of their life history, and allows a plan of recovery to be constructed.

Time spent with service users formulating their life stories and why SCRAs and other NPS use is a significant feature appears to suggest that early trauma, social deprivation, lack of positive role models and feeling disenfranchised from society are common themes. It could therefore be argued that factors such as cost compared to other substances make SCRAs and other NPS attractive and accessible to young people who are, in essence, finding it hard to



Cannabinoid NPS users are usually brought to the attention of crisis mental health services by the local police. Nigel Bowles/Alamy Stock Photo

effectively cope with life events and stressors.

Our continued hope for recovery for this client group is therefore to manage the service user’s acute presentation while holding awareness of their underlying biopsychosocial formulation so a clear collaborative plan of need and intervention can be co-produced. While there is no guarantee that such plans are effective, by ensuring involvement, understanding and collaboration, greater buy-in to support change appears to occur for all involved.

References:

- Home Office, (2016). *Drug misuse: findings from the 2015/16 crime survey for England and Wales.*
- Manchester health and care commissioning, 2017. *New psychoactive substances: briefing for professionals.*

Dr Stephen Donaldson is a highly specialist applied psychologist at the Ayckbourn Unit, Scarborough
Lauren Dowson is crisis team and street triage team manager for Scarborough, Whitby and Ryedale

Reading the signals

Gay men can find it very difficult to seek help when 'chemsex' becomes addictive. **Leon Knoops** explored the issue at Hit Hot Topics

Leon Knoops and Sjef Pelsser are members of the Mainline chemsex team, based in the Netherlands with projects at home and abroad. Their website is a valuable resource at <https://english.mainline.nl>
Photography by nigelbrunsdon.com

Chemsex is the name for combining drugs with sex. Gay men use drugs twice as much as straight men and a part of the dating app culture is to order drugs and find sex parties.

The list of substances being used has grown and a new trend is smoking crack during sex. The crystal meth in circulation is the strongest available on the European drugs market and it's taken by slamming – injecting drugs before or during sex.

In 2014 I started to interview people who had

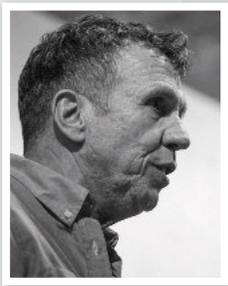
experience and found that a lot of guys had issues – abscesses, blue spots, sharing needles, and many were experiencing mental health issues and sleeping problems.

Many were finding they were unable to have sex without drugs, and more and more men were losing control. Some were losing their houses and belongings, and even contemplating suicide.

It's not done to talk to your friends about this because of the stigma, and there's not enough information or

expertise. So at Mainline we set up chemsex meetings and training for professionals, including STI nurses and consultants. There wasn't enough cooperation initially, so we set up a roundtable that meets twice a year to discuss interventions around chemsex.

The way to connect with those who need help is to use slang and be curious. Don't have judgement but show support – there can be many underlying issues such as loneliness. Let's work together to improve the situation.



'I felt the connection and couldn't stop'

Sjef Pelsser offered valuable insight by sharing his own experience

I had a great job, working for an airline in Holland. I had a lovely partner, my husband. I earned a lot of money and had several apartments.

But something went wrong – there were cracks in our relationship. I decided to end it and fled to an apartment in Sitges. At 53, I felt overdue on the gay scene, but it was easy to install the dating apps. I met a guy in Barcelona – a man smoking a pipe. He gave me to try and I thought it was part of the game.

The effects hit my body and before I knew I had had sex for four days and three nights. I thought holy shit, what is this? And I loved it. But I was worried it would cost me my job – we were not allowed to fly with any substances in our bodies. I had to fly to Toronto, so I thought I'd see if they have the same there – and they did. It was the beginning of my world tour.

I felt the connection and I started smoking crystal

meth. Then I was offered injecting and didn't at first – but when I started slamming, the rush I felt was incredible. I wanted more sex, more guys, I wanted it to go on forever.

But as I came down I had severe depression. My weight went down. I was looking for information, but all I could find was American sites with all those pics of crystal meth users, and I thought 'that's not me'.

So I kept going and met other guys, and I enjoyed the connection. When my mother died, I was partying in Toronto. I was raped and I thought that was part of it. I couldn't go to the police and tell them I'd been taking crystal meth. A lot of people tried to help me, but I didn't want to help myself because I was so into the connection with those guys.

But I was pulled over in Amsterdam and found with drugs. I found myself in jail.

'At 53, I felt overdue on the gay scene, but it was easy to install the dating apps.'

I went to 12-step groups and to addiction counselling. What I was looking for was for people to listen to me, know what I was going through and not judge me. People were judging me because I was part of the gay chemsex scene.

My mission now at Mainline is to find people and help them. I won't judge them – I already judged myself.

STREET SMART



'At present I am working with 33 active clients, while 23 have already completed treatment and are waiting for – or are already in – housing.'

The ISEU project is taking street outreach to the next level, says **Peter Burleigh**

I've been going into hostels, working with homeless people to provide substance misuse support for Turning Point around the Westminster area over five years, but the ISEU project is different. This is outreach on the streets and frontline partnership working in Central London.

ISEU (the Integrated Street Engagement Unit) includes staff from Turning Point, Westminster City Council, the Metropolitan Police, The Connection at St Martins-in-the-Fields (a day centre run by a homelessness charity), The Passage (which operates London's largest voluntary sector resource centre for homeless and vulnerable people), and the Compass team and street outreach (St Mungo's outreach services). It's an innovative project combining integrated health, housing and social care support in order to provide effective routes off the street, with the goal of helping some of the most vulnerable to turn their lives around.

We plan our operations for the upcoming week every Friday, and these can include tent removals, antisocial behaviour enforcement, begging or tackling organised crime. On some days there will be no specific operation and we will go out solely to engage the street homeless and offer social care, medical health and substance misuse support. ISEU recognises that enforcement isn't the most effective way to support people who are sleeping rough, and that long-term we need to be addressing the wider needs of every individual. In every operation there will be a minimum of two plain-clothed police officers who are trained to work specifically as part of ISEU, a city inspector, myself and other partners, depending on the nature of the operation. On larger operations we can have teams of up to 15 people.

When we approach an individual of interest, unless it is a targeted specific police operation (where there is no need for substance misuse expertise), I often lead in approaching and engaging them into conversation. Nine times out of ten, people are willing to have a chat and are receptive. In some cases we're faced with challenging clients who are treatment resistant and will refuse support, and this is usually to do with trust. Every situation is different, but being cautious and confident is key.

When we are engaging with someone, it's important we try to find out the individual's name, age, whether they are currently in a hostel, whether they have been to a day centre, if they have any medical needs and if they are having any problems with drugs or alcohol. When we have a name we can check this against CHAIN, a multi-agency database recording information about people sleeping rough and the wider

street population in London. This enables us to see if the person is seeking any health and social care support from services or charities – if they are not on the database I will give them the details of Connections at St Martins, a day centre where they can register for support services.

Since April 2018 I have engaged with 112 clients, with heroin, cocaine and spice being the most commonly used drugs. Age and gender vary – women often have more complex needs, but can also be more engaged with support. At present I am working with 33 active clients, while 23 have already completed treatment and are waiting for – or are already in – housing. Meanwhile, 18 have dropped out and nine have been referred to Turning Point's drug and alcohol wellbeing service to address substance misuse.

I visit Passage House every week, a 28-day assessment centre for those who have been sleeping rough in Westminster but are not from the borough. Passage House is designed to provide a safe, flexible and supportive environment, and the service uses a trauma-informed approach. Every client has their own room and a designated lead worker. You must be referred by one of the outreach teams, but Passage House offers a wrap-around service, working with people to help them plan a route off the street that is sustainable in the long term.

One of the main challenges we face is reminding individuals that things can't just happen overnight. Getting the right support in place for housing, medical needs, employment, benefits and so on takes time and often requires multiple appointments that need to be attended. We are here to support people in the most efficient way possible, but this also requires mutual understanding and dedication. If people show up on time to appointments progress can be made, but when people don't show up sometimes it means we end up back at square one.

ISEU works really well because every person and organisation brings different skill sets and knowledge, with the same collective aim and commitment to meet it. Prior to ISEU outreach happened in hostels and supported accommodation but the rough sleepers who weren't already seeking any provision were difficult to reach.

I learnt very early on in my career that I have to be able to enjoy my own life outside of this job and not let it impact my personal life – that being said you can't do it if you don't love it, and I have a real passion to help improve people's lives. I wouldn't change it for the world.

Peter Burleigh is an integrated street outreach worker for Turning Point

EXCHANGE

How a unique partnership between UK Steel Enterprise and a local treatment service is helping to provide much-needed support on Teeside

GETTING BACK ON 'TRAC'



FUNDING of £2,220 from UK Steel Enterprise's (UKSE) community support fund is helping to launch an innovative community project in Middlesbrough. TRAC UK, which helps people on Teesside recover from substance and mental health issues, is using the money to start a six-month pilot project to support up to 12 people in two properties, with two full-time staff.

There will be additional support from a volunteer social psychologist and TRAC volunteer advocates to provide tailored recovery plans, with the aim of expanding the scheme to include more staff and properties.

TRAC UK was founded in 2015 by director Annalice Sibley and provides outreach, help with housing and health issues, and a women-only online recovery service.

'We have a great team of workers and volunteers here, and we were thrilled to hear that UK Steel Enterprise had agreed to help us with this new project,' she says.

'There is a big gap for this type of model as it can be easy for people to fall back into old habits if they need to go out of their area to a rehabilitation facility. Clients have told us that being in their local community during recovery would really benefit them. Many are experiencing extreme isolation from mainstream society and need help to access services and work towards recovery and an independent existence.'

While UKSE is usually about supporting businesses with finance and premises, says business development

manager Peter Taylor, its special community support fund exists to support projects 'run by a range of organisations that help to improve the quality of daily life for people living in our steel areas'.

Working in the community also means that TRAC can engage intensively with clients to identify their needs, stresses project administrator Brian Hutchinson. 'Support can range from assistance to get to appointments to group support and one-to-one sessions that help them get to the bottom of their problems, gain a better understanding of their illness and take steps towards recovery.'

More information on UKSE support for community projects at www.uksteelenterprise.co.uk

A SAFE GATEWAY

Police are piloting a health-based approach to drug possession, heard MPs at a recent APPG

'ARRESTING SOMEONE FOR POSSESSION of drugs is usually a deterrent, but the real cost is the rate of drug-related deaths,' chief inspector Jason Kew from Thames Valley Police told the Drugs, Alcohol and Justice Cross-Party Parliamentary Group. These thoughts had led to his force piloting a diversion scheme in West Berkshire as a gateway to reducing harm.

As Dr Wojciech Spyt explained, the scheme aimed to reduce drug-related deaths and drug use, tackle drug-related offending and cut costs to the criminal justice system and other agencies.

The option of treatment would be presented before arrest and did not involve the courts, unlike previous diversion schemes – as long as the person had a quantity small enough for personal use and passed an ID check. Adults were referred to a service provider in their area and young people to the youth offending team (YOT).

In their area, adults were referred to Swanswell, where an initial assessment provided a tailored approach. This could involve drug education for first-time offenders, or a number of treatment pathways for those with more entrenched issues around drugs and mental health.

The resulting headlines in the media, about 'going soft' on drug users, did not reflect the benefits of the scheme, said DCI Lee Barnham. Police officers liked the scheme as it gave them a quick and straightforward route for dealing with people caught in possession of drugs, giving them the time to

'We are locking up people that don't need locking up – they need help and treatment.'

concentrate on pursuing suppliers.

The scheme would run until March, when it would be evaluated and options considered for a further roll-out. One of the main challenges would be finding the funding required for the treatment agency to deal with more referrals.

'We acknowledge that the majority of drug use is

not problematic,' said Kew. 'The idea is to get people familiar with the drug service to reduce drug-related deaths. The aim is for it to be a safe gateway and non-stigmatising.'

The need to change the approach to drug policing was supported by Suzanne Sharkey of the Law Enforcement Action Partnership (LEAP) – a group of criminal justice professionals campaigning for an evidence-based drug strategy led by harm reduction.

A former police officer in the 1990s, working with undercover drugs teams, Sharkey had personal reasons for being passionate about changing policing methods. She had experienced addiction to drugs and alcohol and become homeless and estranged from her children for a period. She felt that the stigma of the situation made it harder for her – and many other women – to engage with treatment and rehab because of fear of social services.

Coming from the North East, she believed much of the social deprivation she had seen was at the route of many issues with drugs and alcohol, and echoed the call for a health-based approach. 'We are locking up people that don't need locking up – they need help and treatment,' she said.

COUNTDOWN TO

NHS England's target date to eliminate hepatitis C is now just six years away. **DDN** hears what progress has been made, and what's left to achieve, at the LJWG on Substance Use and Hepatitis C annual conference. Speaker pictures by **Jon Derricott**

The strategy from NHS England has always been to eradicate hepatitis C,' NHS clinical lead for hepatitis C, Dr Graham Foster, told December's *Seven years to elimination: the road to 2025* event. 'We've never pulled punches – we just want to get rid of the damn thing for once and for all.'

Reductions in drug prices meant this was now achievable, he said, and the strategy had been to split the country into networks and allocate treatment numbers accordingly. 'From the get-go we insisted on outreach treatment, and we insisted on using the cheapest drugs. The strategy is to get out there and find and treat, and we've been pretty successful. We're still not testing enough, but the figures are moving up. We are working, we are curing people, the strategy is being successful.'

Testing rates in good drug services stood at around 95 per cent, while in some it was as low as 5 per cent. 'So the challenge is to move that bottom segment into the top segment'. Treatment in prisons remained poor, meanwhile, and too many needle exchanges still weren't offering testing. However, death rates were falling, as were waiting lists for liver transplants.

But the main challenge was that 'too many people with a history of drug use still aren't getting tested', he said. 'We need to look at the good services and follow their lead.'

'For me it's about supporting services to be doing this treatment themselves,' said nurse consultant at King's College, Janet Catt, adding that peers were

fundamental to reaching marginalised populations. 'A lot of people know they're positive, but hep C treatment can also help them engage more with drug treatment and build goals for themselves,' added peer support worker Chris Laker. 'Word of mouth builds that treatment is accessible and successful. Clients really want this.'

People who inject drugs accounted for 95 per cent of all new diagnoses, consultant hepatologist at Chelsea and Westminster, Dr Suman Verma, told the conference. They were a group that tended to 'dip in and out' of treatment, she said, and were often of no fixed abode, with no GP and no NHS number. 'But they do engage with needle exchanges.'

This is where a recent pilot project offering testing in pharmacies with needle exchange facilities had proved so successful (*DDN*, June 2018, page 5). The aim had been to develop sustainable, effective point-of-care testing and pathways into treatment, she said, adding that it was important that participating pharmacies had adequate facilities for confidential discussion and were able to refer patients with positive tests to the appropriate pathway.

'But what do you do if you have no fixed abode?' The answer was the pharmacies themselves acting as mailing addresses for clients so they wouldn't miss appointment notifications, she said. In the pilot more than 50 per cent of service users were found to be antibody-positive, and 57 per cent of those tested were unaware that treatment was now interferon-free. 'Opportunistic HCV testing in NSP community pharmacies can be really effective,' she stated.

'We all know that hepatitis C is a huge health inequality issue that affects



'It's a travesty that it wasn't part of the mayor's recent report into health inequalities.'
Susan Hall



'People who inject drugs account for 95 per cent of all new diagnoses.'
Dr Suman Verma

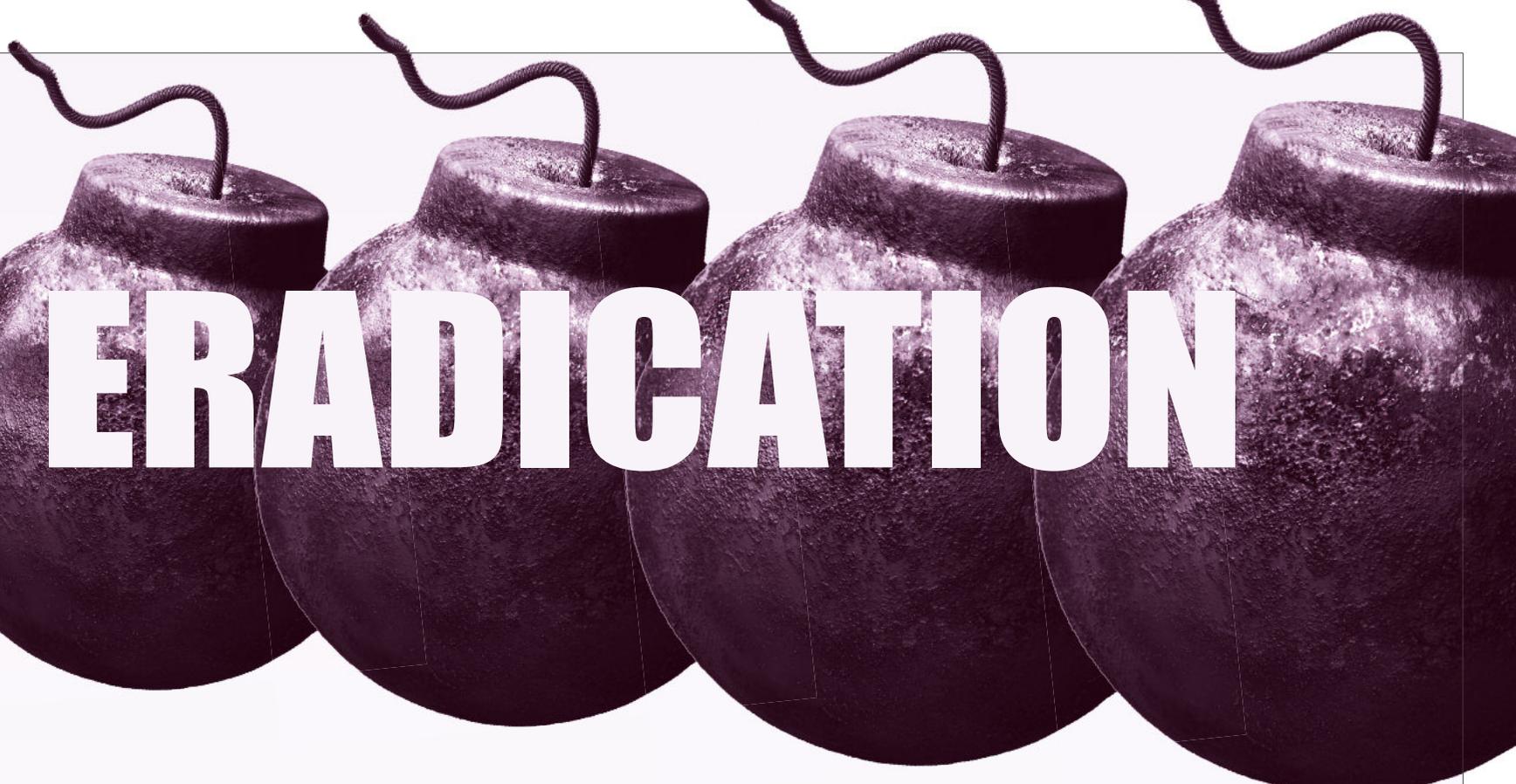


'Anyone who's got a good idea, I'm happy to shamelessly nick it.'
Dr Andy Ustianowski



'Word of mouth builds that treatment is accessible and successful.'
Chris Laker





ERADICATION

some of the most marginalised,' said London Assembly member Susan Hall. 'So it's a travesty that it wasn't part of the mayor's recent report into health inequalities. It shows what a battle we have on our hands to get people to take notice.' There was growing momentum from more and more organisations to take action, however, but this would need a 'huge amount' of joined-up working across often complex networks.

In terms of the practicalities of operational delivery networks (ODNs) meeting their HCV targets, Dr Katherine Morley of the National Addiction Centre at King's College shared the results of an evaluation project on identifying obstacles. Among the main themes that emerged were degrees of confusion over who should be meeting Public Health England (PHE) reporting requirements, as well as issues around referrals to secondary care as a result of service user drop out, often related to time lag. Missing data was also a problem, the result of providers having different electronic patient record systems – 'an endemic problem across the NHS'.

Chair of the British Viral Hepatitis Group, Dr Andy Ustianowski, described the methods used in Greater Manchester's HCV elimination programme, and the lessons learned. The first step was to 'get an idea of what you're dealing with – the numbers', he said, and also to 'get rid of preconceptions'. The next step was always to 'contemplate the simplest model' and work out how to get people to engage for minimal cost.

'Work out what needs to be done – what's absolutely necessary and what's "nice",' he told delegates. 'The "nice" might need to be sacrificed.' The programme was treating around 930 people a year, he said, using community pharmacies and reaching out to treat people's networks. 'Before we treat them we incentivise them to bring their network up for testing.' Also useful were interrogation of records, rapid prison diagnosis and treatment, and – just as importantly – knowing when an initiative had reached its logical conclusion and should be stopped. The programme was currently also scoping the possibility of testing in primary care and A&E settings, he added. 'Anyone who's got a good idea, I'm happy to shamelessly nick it.'

'One of the things I feel in retrospect is why is it so difficult?' said former Hepatitis C Trust chief executive Charles Gore. 'We have these drugs, they cure people – so why does it seem such a struggle?' In the 1990s, after his hepatitis C diagnosis, he had only been able to find one support group, he said. 'Everybody was using heroin, and half of them were nodding out – it didn't feel very supportive.' He had set up the Hepatitis C Trust despite having 'no useful experience', as there was not a single charity for the condition. 'It was very much on-the-job learning. But I cared about people with hepatitis C, particularly those who don't have a voice.'

Although the charity had had to abandon its aim of only employing people with a hep C diagnosis after it proved 'way too restrictive', it was still driven by the belief that 'people with lived experience are incredibly useful', he said, with the role of peers now central to the hepatitis C response in the UK.

Awareness remained a critical issue, and not just in this country, he stated. 'The big problem is that not enough people are diagnosed, and I've become a big convert to the idea of screening. There's now screening in drug services and prisons, but we need to do more of it. And with the cost of the drugs coming down, it means you can spend more money on screening and it will still be cost effective.'

There were now discussions about long-acting injectables for the condition, he told delegates – 'one shot and that's all. It looks like that might be possible', while in the past NHS England's rationing of drugs had been 'appalling' (DDN, April 2017, page 20). 'In my view that was simply because of the assumption that people with hepatitis C were a disadvantaged group, and wouldn't complain too much.'

'I truly think this is doable, and we're beginning to see more and more countries saying, "yes, we want to do elimination",' he continued. 'We have a cure for a disease that kills people, and we don't do it? That's just insane.'

'There are lots of things yet to do, there are still some challenges,' Dr Suman Verma told the conference. 'But we just have to keep on pushing harder.' **DDN**

Read DDN's guide, *Hepatitis C and Health* at <https://drinkanddrugsnews.com/ddn-wider-health-hep-c/>

To view video footage of the event visit Jon Derricott's YouTube channel at <https://www.youtube.com/channel/UCeHbriRijC2pgUPt8HKp0tQ>

'Missing data is an endemic problem across the NHS.'

Dr Katherine Morley



'It's about supporting services to be doing this treatment themselves.'

Janet Catt

'We have a cure for a disease that kills people, and we don't do it? That's just insane.'

Charles Gore

LETTERS AND COMMENT

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

CONSUMPTION ROOMS

RIGHT? THE FIX

We need to talk about safe injecting sites, says **Nick Goldstein**

"In Europe and Australia consumption rooms are the fruit of better funding and treatment philosophy, but in England the situation is different. This is not to say things won't change..."

Gabor Maté

"All substances whether they are opiates, cocaine or anything else are actually pain killers either physical or emotional. All addictions are an attempt to smooth the pain."

Alan Mulholland

It was refreshing to hear a dissenting voice on the orthodoxy around this issue.

LUXURY ITEMS?

I was very interested to read Nick Goldstein's views on the ongoing consumption room debate (DDN, November 2018, page 10). It was especially refreshing to hear a dissenting voice on – as he correctly calls it – the orthodoxy around this issue from the drug user side, as all too often, as with so many subjects in this polarised field, it comes down a black and white, us and them situation with little or no room for nuance.

It was also interesting to hear a more considered take on the 'ignorance-based nimbyism' arguments that would usually be instantly dismissed in the social-media driven rush to judge and condemn that seems to taint all current discourse these days, whatever the subject.

Consumption rooms remain a controversial issue – undoubtedly the right solution in some circumstances and locations, less so in others, and with serious legal obstacles in this country that are very unlikely to be overcome any time soon. And the rarely discussed elephant in the room, as he points out, is that a very sizeable proportion of injecting drug users would probably never go anywhere near one.

If anyone from the other side of the fence had called consumption rooms 'a luxury in an age of austerity' they would have been burned at the Twitter stake, so all credit for sharing some honest, and persuasively argued, views.

Alan Mulholland, by email.

CAKCLING CONSPIRACY

For a man who is so obviously accomplished and preeminent in his field, Professor David Nutt can often come out with some bizarre statements. 'The main reason why drugs are illegal is because that's what the media and politicians want,' he says (DDN, December/January, page 16). This plays into the current narrative that the media is run by cackling Bond villains, determined to plant their evil lies into the minds of their credulous, malleable readership.

Media owners are interested in one thing – making money. The Daily Mail, Express and so on sell millions of copies because they reflect the views of their readership. If their readers were all liberal progressive types who wanted drugs to be decriminalised or legalised and regulated, then that's what these papers would be advocating. They don't. And politicians, equally, are unlikely to go out on a limb to advocate for something that they know the vast majority of their constituents are firmly against, as any glance at the current news will attest.

Paul Stansfield, by email

  /DDNMagazine @DDNMagazine
www.drinkanddrugsnews.com



A DIFFICULT START

Finding out about a person's trauma in early life can go a long way in helping them cope, says **Andrew Bennett**

THE EFFECTS OF ADVERSE CHILDHOOD EXPERIENCES (ACE) can manifest in adulthood and have a cumulative effect – and are one example in public health where disadvantage stacks up.

An ACE count shows how stress can affect young children. If there is a regular 'drip drip' effect, and if they are in constant fight or flight mode, it can affect young brains and might manifest in their behaviour. Children can become isolated at school, which can escalate and cause lifelong problems.

Not only can this make it difficult for people to access help, but US research shows that people with an ACE count of six or more can die 20 years earlier.

People with high ACE counts are much more likely to have problematic drug or alcohol use; as Gabor Maté has pointed out, many individuals with problematic drug use have roots in trauma – so trauma can be the gateway to drug use. Mark Gilman has also made the distinction between taking drugs for pleasure and taking them because life is unbearable.

But your ACE count is not your destiny. It can be changed with the right support, and services can become 'ACE aware'. Take an ACE lens to your service and see what difference this increased knowledge and awareness could make to your work.

So how can we strengthen individual resilience? We need to understand the trauma that's played out in people's lives. We need to help people develop survival strategies and flip 'what's wrong with you?' to 'what's happened to you?'

Make the case to routinely enquire about ACEs. We rarely ask about them, but it creates an opportunity to talk about problems and helps to empower people. Evidence shows that asking questions does not increase trauma.

Sixty per cent of people with ACEs have never divulged them to a health practitioner before. It's a straightforward process – four key steps to make a pathway to provide care. It's important for services to have ACE awareness built into them.

Andrew Bennett is an independent public health practitioner, currently supporting the National ACE approach to policing vulnerability programme in North Wales.

*This article is taken from his speech to the Hit Hot Topics conference
Photography by nigelbrunsdon.com*



SO, HOW ARE WE DOING?

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

IN MY PREVIOUS ARTICLE, I described the policy and financial strategy that the last Labour government used to build the national drug and alcohol treatment system we all now work within. This time, I want to take an unvarnished look at the results achieved over the last 15 years with the billions of pounds of taxpayers' money that has been expended. Most readers will know that the picture has been mixed.

My personal view is that we have not achieved everything we set out to do because, despite political

support and big investment, the system we have created is too often process driven and bureaucratic, and insufficiently human and welcoming. The evidence is stacking up that the key precondition for engagement and behaviour change is human connection (Johann Hari sums it up well), and the services that have most impact are the ones that get this right.

For too many marginalised people, their experience of services is too much form-filling and onward

referral, and not enough inspiration and consistent personal support. If we want people to change and grow, we have to give them more reasons to believe that a different life is possible.

So how do we get better at facilitating real change, when the sector is under the pressure of cuts, and our clients' lives are getting harsher? That is now the challenge we face, which I will address in my next article.

Mike Trace is CEO of Forward Trust

REASONS TO BE CHEERFUL

✔ We have one of the most comprehensive publicly funded treatment systems in the world, with a high rate of 'penetration' (proportion of the population in need who are in touch with services). This major investment in care and support for some of the most vulnerable people in society is both humane and cost effective.

✔ We have been successful in reducing drug-related crime, with Home Office research concluding that our treatment system was a key contributor to the reduction of overall crime rates between 2000 and 2010 (although recent trends seem to indicate that this effect is waning).

✔ We have been successful in keeping drug-related HIV infections low. The UK was an early adopter of harm reduction practices such as needle exchanges in the 1980s. As a direct result, HIV transmission rates from injecting drug use have remained among the lowest in the world. (Once again, the scope and quality of harm reduction services has recently been under pressure, which may lead to an upturn in infections).

REASONS FOR CONCERN

✘ We have not been able to reduce the scandalous level of drug-related overdose deaths, that remain way above European averages. There has been much discussion around the reasons for this, but the fact remains that one of the key objectives of having a well-funded treatment system was to significantly reduce the misery caused by these premature deaths, and we have not yet succeeded.

✘ We have not been good at moving people through the treatment system into positions of independence and wellbeing. Apart from the missed potential for individuals, this has created a 'system' problem where capacity demands on services constantly increase as new clients outnumber those who move into recovery.

✘ We have not sufficiently overcome the funding and delivery 'silos'. We all know that drug/alcohol treatment clients have multiple needs, but there are not enough examples of truly integrated planning or care and, conversely, sometimes duplication of services. In particular, substance misuse and mental health services still work to separate methods and objectives, and support for children and family members is still an underfunded afterthought.

HOMELESSNESS

Homelessness may be a complex issue but we know how to make a difference, heard delegates at a conference that brought together academics and experts by experience. **DDN** reports

BECOMING VISIBLE

‘**O**utreach workers would try and contact me, but I couldn’t hear, they couldn’t get through. I was fretful and frightened.’ Kevin Dooley is now a recovery programme consultant, but at a conference on addressing complexity: homelessness and addiction’ he cast his mind back to a time when he was homeless, addicted to drugs and alcohol, and in and out of prison.

‘I would wake up when I was homeless and not know what time it was – I didn’t know the day or the month,’ he said. ‘I would open my eyes and see Boots the chemist through the gloom, and I’d know I could shoplift.’

When Dooley left prison, he ‘was on everything but roller skates’, but had no support, no crisis plan, no therapy, and was homeless. Vulnerable in every way, he found it impossible to ask for help.

‘Vulnerable people are being penalised rather than supported,’ he said. ‘To penetrate this, we need to understand the problem... Why do people get out of their heads every day? To become functional, to find a sense of wellbeing. Homelessness is not an intelligence deficiency. Addiction is not an intelligence deficiency.’

We needed to attempt a much deeper understanding, which would help to develop more reflective practice, he said. Relationships were important and sometimes all people needed was ‘a good listening to’. But it was essential to become fully informed about the effects of trauma in early life and realise that ‘the problem was there before the drug dealer came, before the first drink’.

‘It’s a growing problem that’s getting worse and that we need to do more to address,’ said conference chair, Prof Tony Moss. Each measure of homelessness had increased across England since 2010 and deaths of homeless people had increased by 24 per cent over five years.

When represented in the media, the problem was caused by drugs, alcohol, Siberian winds – but never by austerity. ‘The question really should be “why is this problem happening in the first place?”’, he said. ‘It’s important not to perpetuate the myth that people are dying because of drugs and alcohol.’

LACK OF COMPASSION

Most deaths attributed to drug poisoning were ‘thoroughly preventable’, said Prof Alex Stevens, of the University of Kent. ‘The problem is not lack of evidence, but lack of compassion. It’s a class attempt to write people off and not think of them as fully human.’

Leading a report for the ACMD on how to reduce deaths in 2016, he had recommended opioid substitution therapy (OST), drug consumption rooms (DCRs), integrated services, and ‘putting naloxone everywhere’. Latest data from PHE showed that only 12 per cent of people were leaving prison with naloxone, when the odds of death from overdose were eight times higher without it.

‘We should be getting people into treatment and keeping them there,’ he said, explaining that people were nearly twice as likely to die when they were out of OST. Treatment should also involve service integration and assertive outreach, linking drug and alcohol treatment to housing, mental health support, HIV and HCV testing, help with employment, relationships, diet and exercise, and smoking cessation.

There were many things that we could do and should be thinking about ‘rather than just getting people on a script’, he said, such as offering vaping pens to replace the ‘crappy roll-ups’ that caused lung disease.

With evidence being ignored on many initiatives that would have a positive impact, Stevens concluded that the main barriers in drug policy were ‘power and morality’; fiscal policies had redistributed wealth upwards and you were nine times more likely to have a drug-related death if you were from one of the poorest communities. We needed to change the narrative, he said, humanising people who use drugs as ‘people worthy of compassion and fully worthy of respect’.

There were many practical things that we could do to improve life for homeless people, the conference heard. In his opening address Prof Tony Moss said, ‘we’re not particularly good at working together’, so the event went on to share a wide range of expertise.





Meibion / Alamy

NO HELP FOR SMOKERS

Dr Lynne Dawkins of London South Bank University (LSBU) explained the strong link between homelessness and tobacco use and looked at opportunities for harm reduction. Smoking killed around 200 people a day in England and was responsible for more than a quarter of cancer deaths – and with the average pack price almost £10, it was expensive.

‘You’d expect people on the lowest incomes to be the most sensitive to price changes, but that’s not what the evidence shows,’ said Dawkins. ‘Those who smoke can least afford it.’ While there was a slow but steady decline in smoking in the population as a whole, there were widening health inequalities in people who smoked. It was estimated that 77 per cent of homeless people smoked, which could exacerbate the onset of psychosis.

‘The desire to quit is no less in the homeless population, but attempts are often unaided,’ she said. ‘In some cases, smoking cessation is discouraged as it’s felt they can’t deal with it – that it’s “the only pleasure they have”.’

Evidence had shown e-cigarettes to be 95 per cent less harmful to health than smoking, eliminating the tar and the exposure to 4,000 chemicals, including 60 carcinogens. They gave much faster delivery of nicotine than patches, could replace the all-important hand-to-mouth activity, and didn’t feel like a ‘quit attempt’ to many that tried them. So why aren’t we considering e-cigs for the homeless, an extremely nicotine-dependent population, she asked.

NOTHING TO LOSE

Another problem that disproportionately affected homeless people was gambling, and Dr Steve Sharman of the University of East London who had looked at whether gambling was a cause or a consequence of homelessness. ‘Most gamblers have problems before becoming homeless, but also a smaller proportion took it up afterwards – so it’s more complex than we thought,’ he said.

He shared case studies which showed the gradual onset of a gambling habit. Dean’s gambling had started when he was 14 and used to go with his father to collect his mother from the bingo hall. Playing on the slot machines while they were waiting became the start of a habit that led to stealing from friends and family, spending all his wages, becoming homeless when his landlady evicted him for not paying the rent, and two suicide attempts.

Tom was abused from a young age and in care at ten, discovering drugs and alcohol as a way of escaping the negativity he was feeling. He and his girlfriend had a baby at 15, when his gambling career started with interactive tv games; before long he was spending their child benefit in the bookmaker’s, committing burglary, street robbery and violent crime to fund the habit, and became homeless after a spell in prison.

Using the information from personal stories, Sharman was developing a series of tools including a resource sheet with immediate tips and safeguarding measures (freely available at www.begambleaware.org). Fewer people were aware

of treatment services for gambling than for drug problems, so the challenge was to find those in need of help, particularly if they were ‘lost’ to the system.

BODY AND MIND

One of the other key areas for review was effective treatment for dual diagnosis, where poor mental (and physical) health overlapped with substance misuse – a situation all too common in homeless people. Using qualitative research, Dr Hannah Carver of the University of Stirling had looked at what could be effective for people in this situation.

As well as long-term, tailored treatment that looked at underlying conditions, it was found that peer support and compassionate non-judgemental staff were important to outcomes. The right environment and the right intervention needed to be paired with stability and structure, and opportunities to learn life skills. ‘Services should be facilitative and friendly, treating people “where they’re at”,’ she said.

CARE PATHWAYS

Across every facet of healthcare there was evidence-based information that could go a long way to improving the lives of people experiencing homelessness. But as Dr Michelle Cornes of King’s College London demonstrated, the theory came to nothing if multi-professional teams did not work as a unit around the person needing help.

‘The picture is very fragmented,’ she said. ‘We often talk of the need to get physical health better before mental health.’ But pathway teams, including nurses, GPs, housing workers, social workers and occupational therapists, needed to be part of the care team – demonstrated in the case of hospital discharge. The recuperation, rehab, resettlement and recovery were all part of intermediate care that ‘has been shown to give enormous benefits’, she said. She introduced Darren and Jo, experts by experience, who explained what happens when the care pathway breaks down.

‘The problem is not lack of evidence, but lack of compassion. It’s a class attempt to write people off and not think of them as fully human.’

HOMELESSNESS

Jo had been discharged from hospital to the street with a gutter frame to aid her walking. She had no money and a 0.6 mile walk to her usual sleep site. She then had to walk a total of 6.8 miles on her walking frame over the next two days – to the GP surgery, the day centre to see if there was an emergency bed for the night (there wasn't one with disabled access), back to the sleep site, to the 'appointed' chemist to pick up methadone, back to the GP for assessment, back to the chemist, back to the GP, until finally a taxi was arranged to take her to an intermediate care bed in a local hostel.

'Why are we still discharging to the street?' asked Cornes. In 2012 a report published by Homeless Link and St Mungo's suggested that up to 70 per cent of patients who were homeless were being discharged to the street. In response, the Department of Health and Social Care had released a £10m cash boost to improve hospital discharge arrangements, which had funded 52 specialist homeless hospital discharge (HHD) schemes across England. King's College had been commissioned to evaluate the schemes over three years, with the aim of showing how to deliver safe transfers of care.

The evaluation showed that homeless people were not being treated the same as others in hospital – for example homeless older people were not being given the same delayed discharge as a patient from a stable background waiting for a care home, to make sure there was somewhere they could go. The intermediate care that had been shown to give 'enormous benefits' was in very short supply, even though it was shown to be 'far more cost effective' in schemes that had it than schemes that didn't.

Arranging help on the day of discharge could be invaluable in sorting essential logistics – transporting belongings, registering at the drug service to collect methadone, finding a tenancy that was safe and secure with some heating and basic food ready for arrival, and making sure the person was not alone if they were still feeling unwell.

'Why are we still discharging to the street?'

'We're not that interested in methodology – we want stuff that helps us do our job.'

MOTIVATION TO DRINK

When thinking about longer-term support, it was helpful to know more about motivation said Mick McManus of Barking and Dagenham, who introduced a survey

on street drinking in East London. 'What was their background, what motivated them to drink? Answers to these questions would help to mould our integrated service,' he said.

Dr Allan Tyler of LSBU explained how their 12-month programme – a collaboration between Westminster Drug Project and LSBU, funded by the London Borough of Barking and Dagenham – combined research and outreach to understand patterns and motives.

The experiences that the team recorded were diverse and showed that not all of the people street drinking were homeless. One important conclusion was that the rich nature of people's experiences meant that they were not going to create 'types of street drinkers'.

Among the findings were that many wanted to find a way out of their drinking behaviour, but couldn't find a path. Others felt stigmatised as 'weak' or were excluded from programmes because of a violent past and time in prison. One participant, when asked about giving up alcohol said, 'Why would I do that? To be the healthiest homeless person in Britain?'

THE HUMAN TOUCH

Throughout the conference academics shared their findings, but they were illuminated throughout by the contributions of people with lived experience – more relevant than ever representing a population considered 'hidden'.

'Your past is not a life sentence,' said Kevin Dooley. 'Human beings are capable of change and I've lived on second chances all my life... These people are valid and have a voice. These are the ones we need to help us move forward. We can go further and dig deeper – people with experience can contribute to the research and the analysis.'

Lucy Holmes, research manager at St Mungo's also issued a challenge to researchers – to make their work accessible and easy to absorb.

'We're not that interested in methodology – we want stuff that helps us do our job,' she said, and this could be aided with checklists and toolkits, such as the recent kit on naloxone. Through a lively presentation she urged researchers to get in contact with St Mungo's, to work together.

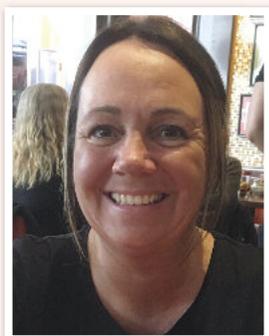
'We do a lot of lobbying, influencing work,' she said. 'We sit on project groups, talk to commissioners every day, and we want our messages to be research led. If you want to have real-world impact, talk to us. We talk to the public a lot.'

'Your research today must reach the coalface,' agreed Dooley, before chair Tony Moss gave his final thoughts. 'It's a relationship between complexity and compassion,' he said. 'The more you engage, the more complicated it becomes – but that's important, because otherwise research is technically inaccurate. Good quality research can start to unpick complications.'

'The sooner you realise a person isn't in a situation because of the decision they made, the more compassionate you become,' he added. 'A whole lot of things in life are out of your control.' **DDN**

Addressing complexity: homelessness and addiction was organised by the Centre for Addictive Behaviours Research and the London Drug & Alcohol Policy Forum, and held at The Guildhall, London.





Finding the detox or rehab that fits the bill

Quality is all about making sure services match your clients' needs, says Turning Point's regional head of operations, **Amanda Lacey**

It is estimated that since 2013-14 spending on residential detox and rehab has reduced by 14 per cent, while in some areas the budget has been reduced by as much as 58 per cent.

Over the course of my career I've seen a shift towards spending on community drug and alcohol services away from residential detox and rehab, but for many people residential detox and rehab can play a vital role in their recovery. At Turning Point, we provide residential detox at Smithfield in central Manchester and we have two residential rehab facilities: Stanfield House in Cumbria and Leigh Bank in Oldham.

Local authorities have less money to spend on detox and rehab than ever before, which means that when they make a referral they need to feel really confident about the quality of the service the person will receive. The quality of our residential detox services at Smithfield was praised by CQC inspectors following their last visit and Stanfield House, our residential rehab in Cumbria, has just been rated 'good' with areas of outstanding practice. Unfortunately, quality is by no means a given in this part of the sector. In 2017, CQC published a review of quality in residential detox facilities; nearly three-quarters were found to be failing in at least one of the fundamental standards of care.

Quality isn't just about clinical guidelines, it's also about ensuring the service is genuinely accessible and tailored to the individual's needs in order to maximize their chances of success. This might be about getting a person in quickly. Turning Point are able to offer a detox bed within 21 days, while for our rehabs it can be within a week. It might be about having treatment programmes in place that respond to emerging trends in substance use – at Smithfield we have developed a detox for spice, which is a growing problem in some parts of the country. It might be about purchasing a package of treatment and support that is tailored to a person's particular circumstances. We have introduced a three-day 'kickstart detox' which is good for high-functioning dependent drinkers who are in work and can come in over a weekend and



'At Turning Point we believe that listening to our clients is the key to developing responsive services... With successful completions at 82 per cent last year, I feel like we've got this one right.'



then continue the detox in the community. Alternatively this might be a good approach for someone who is suitable for a community detox but is socially isolated and may not have friends and family to keep an eye on them during the first three days, the most high-risk stage of the detox.

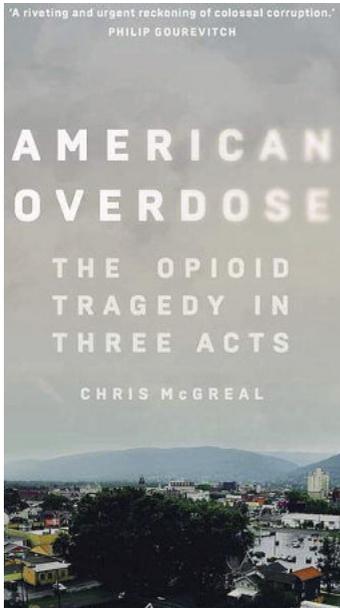
When there was more money available for residential services, there was still unmet need. People with caring responsibilities, such as those with children, have often been excluded from residential services, so Turning Point has

introduced 'dayhab'. This allows people to get all the benefits of a 12-week rehab programme, including developing therapeutic alliances with other service users, while still being able to return home to their families at night. At Stanfield House we also have kennels, which means that people can bring their dog.

At Turning Point we believe that listening to our clients is the key to developing responsive services that provide what people need, at a price commissioners are willing to pay. With successful completions at 82 per cent last year, I feel like we've got this one right. A piece of feedback from a client at Smithfield comes to mind: 'To each and every one of you from day staff to night staff. You made me feel like a person and not a problem and I always felt safe.'

To make a referral to any of Turning Point's residential detox services call 0161 827 8570 or email Smithfield.admissions@turning-point.co.uk, For our Leigh Bank residential rehab service call 0161 212 1435 or email david.ryan@turning-point.co.uk and for our residential rehab service at Stanfield House please ring 01900 65737 or email kate.rimmer@turning-point.co.uk

AMERICAN OVERDOSE - By Chris McGreal



American Overdose
by Chris McGreal
Published by Faber
£12.99 paperback

IT'S 20 YEARS SINCE PRESCRIPTION OPIOID OVERDOSE DEATHS FIRST SHOWED A SHARP RISE. Since then, an epidemic has taken 350,000 lives. Synthetic morphine use rocketed, especially after OxyContin became available in 1996. (It is pure oxycodone, which, like hydrocodone, stops the nervous system sending signals to the brain). In 2007, Purdue Pharma was found guilty of false safety and effectiveness claims for OxyContin. It wasn't until 2018 that Purdue finally 'announced it would no longer market the drug to physicians,' says McGreal.

Throughout that period, the pharmaceutical giants bought off law-makers, including the Food and Drug Administration in Washington, which approves medications. No current staff member was available to the author. Big Pharma also rigged the medical debate about prescription opioids, manipulating badly evidenced science, to say on the original label that 12-hour, slow-release absorption 'is believed to reduce the abuse liability of the drug'.

One outlet for opioids with no questions asked was 'American Pain', as though pain is different and worse in America, and in a society which believes you can buy and sell any dream, no-one should feel any pain.

Pills were poured into vulnerable places, particularly West Virginia. In its coalmining areas, there had been industrial injuries. Going into decline, the pain became more emotional. People saw themselves as poor failures. In a national culture of money and success, many in marginalised, shrinking old communities felt inferior. Until they first tried opioids.

'Not only did it take my pain away. I felt, wow, this is amazing'.

The double-whammy is that testimony came from a doctor. 'I like my job' (now he was taking Norco, a hydrocodone), 'I'm not irritated by my patients anymore'. He handed them 30,000 opioid prescriptions in five years, and some died from overdoses. When the doctor, like many others, was eventually jailed, fellow prisoners explained the deadly scams he'd helped trigger: 'Dealers shuttled busloads of hard-up elderly people from out-of-state for prescriptions, then paid a few hundred dollars for half the tablets.'

Pill mills, with manufacturers, bogus academic institutions and distributors all complicit, meant that 9m doses were delivered to one West Virginian pharmacy in two years. It was in the town of Kermit, with its population of circa 400.

When, finally, some limits to prescribing came in, inevitably heroin use leapt. At 15,000, it exceeded synthetic opioid deaths, by 2014. Then fentanyl (synthetic heroin) took over, with 20,000 overdose deaths by 2016.

So the crisis, which has netted Purdue Pharma alone \$40bn, goes on. McGreal concludes that for the big drug producers, and the agencies they colluded with everyone is to blame, so no-one is to blame. Except the addicts.'

Review by Mark Reid

One outlet for opioids with no questions asked was 'American Pain', as though pain is different and worse in America.

MEDIA SAVVY

The news, and the skews, in the national media



COCAINE IS LIKE PORNOGRAPHY; everyone wants to believe that regardless of the misery and broken lives which litter the production of everybody else's kicks, the source we alone opt for is magically free of exploitation, torture and death. In my day we kidded ourselves that growing the coca plant gave the farmers of South America a good living, which was

'In my day we kidded ourselves that growing the coca plant gave the farmers of South America a good living.'

pathetically self-deluding enough, but it's always easier to lie to ourselves about the plight of people in faraway countries of which we know nothing. Today, it would be an actual moral cretin who could ignore the human collateral which is left lying in the wake of the 'cheeky' line of coke which brings a sparkle to the eye of the after-dinner educated.

Julie Burchill, Spectator, 5 January

SURELY IT'S TIME for government (with hefty contributions from event organisers and club owners) to fund pill testing everywhere young people gather – in city centres, clubs and at festivals. Testing should be a normal part of a party night out... It is hypocritical to allow such a key service as The Loop to be crowd-funded, when the results of drug misinformation and misuse often have to be dealt with by the hard-pressed NHS.

Janet Street-Porter, Independent, 4 January

ANYONE WITH HIS WITS ABOUT HIM knows that there are far more crazy people about than there used to be, many of them with knives, and it isn't much of a stretch to connect this with the fact that the police and the courts have given up enforcing laws against marijuana, which some idiots still say is a 'peaceful drug'... Amazing that, as

the evidence of its danger piles up, we should even be thinking of legalising it here, as the Billionaire Big Dope Lobby wants.

Peter Hitchens, Mail on Sunday, 6 January

THE ASPIRATION TO BE HEALTHIER is a form of self-gentrification. In all our cities and small towns we can see the consequences of addiction: to smack, crack, spice, alcohol. We see it in our hospitals and in the rough sleepers in our shelters, and yet rehabs are closing down or are entirely privatised. Those who most need help are not able to access it and are caught in downward spirals of addiction and mental health issues... This process of eliminating all that is bad from one's life in order to feel better is just not possible for many people in the way that it is spoken about. We live in a social body, not isolated temples of purity.

Suzanne Moore, Guardian, 8 January



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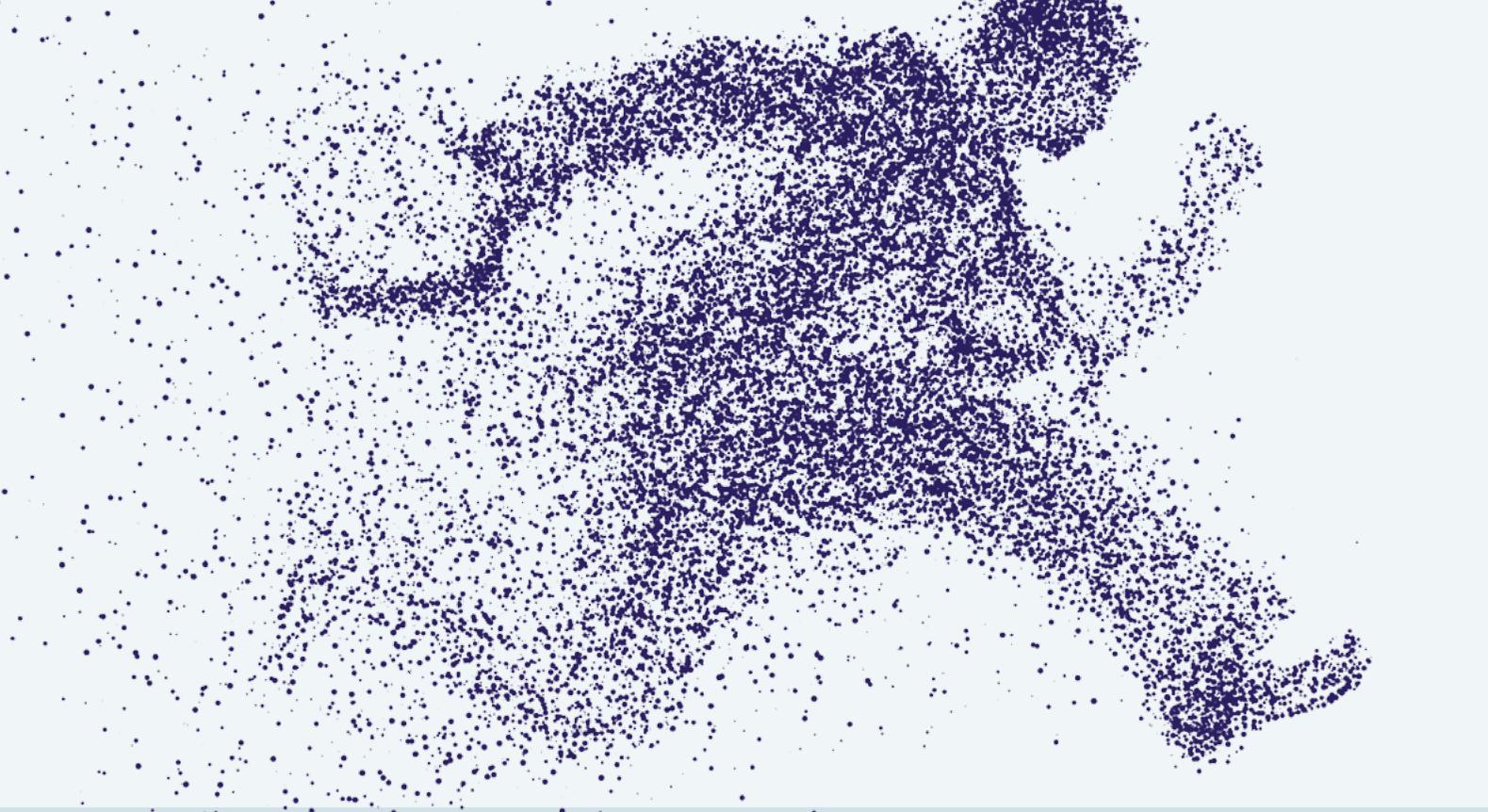
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Nick Goldstein, writing in DDN, June 2018

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