# DRINK AND DRUGS NEWS

# DDN

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# TIME TO MAKE SOME NOISE

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## EDITOR'S LETTER

**'Harm reduction is not the preserve of one community'**

pic: nigelbrunsdon.com

September is a glorious opportunity to celebrate recovery month and we're delighted to hear about the activities taking place all over the country. The Recovery Games in Doncaster (page 16) sums up the spirit of events and we're looking forward to following what's happening around the country.

But as we do so, let's remember our common purpose. Harm reduction is not the preserve of one community – it's all of our business and should be central to everything we do, whatever the drug and whatever the treatment preference. Nick Wilson's piece (cover story, page 6) is a reminder that activism is essential, and that includes the kind of community engagement that makes recovery messages so visible and effective. The 'culture of acceptance and engagement' should be the unifying force that propels harm reduction to the heart of mainstream healthcare and policy. We have plenty of evidence for this, right down to the depressing year-on-year increase in drug-related deaths.

The evidence is particularly clear when looking at custody-community transitions (page 14) – an area where small changes in practice could make a vast difference to prisoners' chances of success. As Alex Stevens points out, there's much that can be done in the short term for a population 'so highly vulnerable to health problems'. Meanwhile, in this month's News Focus (page 8) we look at progress on hepatitis C and find some important messages on data sharing if we are to meet NHS England's ambitious elimination target of 2025.

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

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# HIGHEST DRUG DEATH TOLL FOR ENGLAND AND WALES – AGAIN

**REGISTRATIONS OF DEATHS** relating to poisoning (overdose) in England and Wales have once again broken previous records, according to figures from the Office for National Statistics (ONS). There were 4,359 drug poisoning deaths in 2018, up from 3,756 the previous year (*DDN*, September 2018, page 4). This represents a 'statistically significant' increase of 16 per cent, the highest since records began in 1993.

The figures follow the announcement in July of another set of record drug-fatalities north of the border, at 1,187 – the fifth consecutive Scottish increase and up almost 30 per cent from 2017's figure of 934 (*DDN*, July/August 2018, page 4). The Scottish Government has since announced an additional £20m funding over two years for the country's drug services.

Two-thirds of the fatalities in England and Wales were related to drug misuse, with male deaths increasing significantly from 89.6 per million males in 2017 to 105.4 in 2018, while the female rate increased for the ninth consecutive year to 47.5 per million. While more than half of all drug poisonings involved an opiate, deaths involving cocaine have now risen for seven years in a row and almost doubled between 2015 and 2018 – to 637. Fentanyl deaths, however, remained stable at 74.

There were also 125 deaths involving NPS, once again a 'statistically significant' increase from the 61 recorded in 2017 and a return to 2016's levels, which saw 123. Synthetic cannabinoids contributed to 60 of the NPS-related deaths, up from 24 in 2017. As in previous years, the North East reported significantly higher drug-related death rates than all other English regions.

Transform called the deaths 'an avoidable tragedy', while Release said government inaction was a significant contributory factor. 'For the last seven years we have seen drug-related deaths increase year on year and every year we have called on the government to take action, to scale up funding for drug treatment, to support overdose prevention sites, to fund drug checking facilities, and to expand heroin assisted treatment,' said executive director Niamh Eastwood. 'Each year they have ignored us.'

'Every year we have called on the government to take action, to scale up funding for drug treatment... Each year they have ignored us.'

NIAMH EASTWOOD

'Drug-related deaths are preventable deaths,' added Turning Point's director for public health and substance misuse, Jay Stewart. 'Investment in high quality, free to access, evidence-based treatment services is critical, not only to protect communities from drug-related crime and anti-social behaviour but to save lives. Nationally, funding has been reduced by 18 per cent over the past five years and this reduction needs to be reversed.'

*Deaths related to drug poisoning in England and Wales: 2018 registrations at www.ons.gov.uk*

## DELAYED GRATIFICATION

**ALCOHOL COMPANIES WILL FINALLY INCLUDE THE CMO'S REVISED DRINKING GUIDELINES on bottles and cans three and a half years after their introduction. Portman Group members – which include Diageo, Barcardi and Carlsberg – will now voluntarily display the 14 unit guidelines on their packaging. Institute of Alcohol Studies chief executive Katherine Severi said that it was a victory for the public that the guidelines would appear 'after three years of delaying tactics by alcohol companies, and at the last minute before a government deadline to comply. But while this marks a half step forward, it shows that the current system of alcohol industry self-regulation is failing consumers.'**

A victory for the public

KATHERINE SEVERI

## RIGHTS VIOLATIONS

**THE UN HUMAN RIGHTS COUNCIL** should open an investigation into Rodrigo Duterte's 'war on drugs', says an Amnesty International report. The Philippine president's violent anti-drugs campaign should be investigated for gross human rights violations and 'possible crimes against humanity', according to *They just kill*. While the country's government had acknowledged at least 6,600 killings by police, 'evidence points to many thousands more killed by unknown armed persons with likely links to the police', Amnesty states. 'It is time for the UN, starting with its Human Rights Council, to act decisively to hold President Duterte and his government accountable,' said Amnesty regional director Nicholas Bequelin. *Report at www.amnesty.org.uk*

## CYNICAL EXPLOITATION

**CHILDREN AS YOUNG AS SEVEN are being exploited by county lines gangs, says a Children's Society report. While those in the 14-17 age range are the most likely to be exploited, children of primary school age are being 'increasingly targeted', the charity warns. The number of 10-17-year-olds arrested outside London for intent to supply drugs increased by 49 per cent between 2015-16 and 2017-18 to more than 500, while respondents described seven and eight-year-olds receiving support from the authorities. 'Children are being cynically exploited with the promise of money, drugs, status and affection and controlled using threats, violence and sexual abuse, leaving them traumatised and living in fear,' said Children's Society chief executive Nick Roseveare.** *Counting lives: responding to children who are criminally exploited at www.childrenssociety.org.uk*

## EFFECTIVE IMPLEMENTATION

**MUP IS BEING IMPLEMENTED EFFECTIVELY**, according to NHS Health Scotland. Levels of compliance among licensed premises are high, says *Evaluating the impact of minimum unit pricing in Scotland on harmful drinkers*. The report, which is based on interviews with trading standards officers, police and others, found that even where issues of non-compliance were identified these were 'minor and swiftly resolved'. Pubs, clubs and restaurants – which charge higher prices than off-sales premises – had been largely unaffected, and there was also no reported increase in incidences of unlicensed or illegal alcohol activity since MUP's introduction in May last year. *Report at http://www.healthscotland.scot/*

# MORE RESEARCH NEEDED ON MEDICINAL CANNABIS, SAYS NICE

**MORE RESEARCH IS NEEDED** on cannabis-based medicinal products before they can be widely prescribed, says the National Institute for Health and Care Excellence (NICE). Medicinal cannabis products were re-classified last year to allow specialist doctors to prescribe them where the needs of patients could not be met by licensed medicines. The decision followed the high-profile cases of two children with epilepsy whose parents were unable to legally access cannabis oil-based medicines to prevent their seizures (*DDN*, July /August 2018, page 5).

NICE has issued draft guidance for public consultation on the use of cannabis-based products for people with severe treatment-resistant epilepsy, chronic pain, spasticity and intractable nausea and vomiting as a result of chemotherapy. The guidance makes a range of recommendations for further research based on the 'overall lack of clinical and cost-effectiveness evidence' for the products. The guidance states that, other than pure cannabidiol (CBD) used 'on its own in the context of a clinical trial', no cannabis-based products should be used for treating chronic pain, while Sativex should not be used for treating spasticity in people with multiple sclerosis as it was not found to be cost-effective in relation to its benefits.

> 'We recognise that some people will be disappointed that we have not been able to recommend the wider use of cannabis-based medicinal products'

NHS England has also published a review of the barriers to prescribing the products, which states that the lack of evidence regarding their long-term safety and effectiveness has 'weighed heavily on prescribing decisions' and recommends that two major clinical trials be set up. It also states that 'consistency is key' when making decisions about the use of medicinal cannabis for children with severe epilepsy, as without sufficient clinical trial evidence clinicians were 'very reluctant' to prescribe.

'We heard loud and clear the concerns and frustration the children's families are feeling, but these recommendations aim to help us develop the evidence base to understand how safe these products are, and ensure education and expert advice is available to support clinicians across the UK,' said chief pharmaceutical officer at NHS England, Dr Keith Ridge.

'We recognise that some people will be disappointed that we have not been able to recommend the wider use of cannabis-based medicinal products,' added director of NICE's centre for guidelines, Paul Chrisp. 'However, we were concerned when we began developing this guidance that a robust evidence base for these mostly unlicensed products was probably lacking. Having now considered all the available evidence it's therefore not surprising that the committee has not been able to make many positive recommendations about their use.'

Director of external affairs for the MS Society, Genevieve Edwards, said her organisation was 'bitterly disappointed' by the guidelines. 'NICE's refusal to recommend cannabis for pain and muscles spasms, or to fund Sativex on the NHS, means thousands of people with MS will continue to be denied an effective treatment,' she said. 'MS is relentless and painful, yet not a single person with MS has benefited from medicinal cannabis being legalised nine months ago.'

*Draft guidance at www.nice.org.uk/guidance/indevelopment/gid-ng10124/documents. NHS review at www.england.nhs.uk/medicines/support-for-prescribers/cannabis-based-products-for-medicinal-use/*

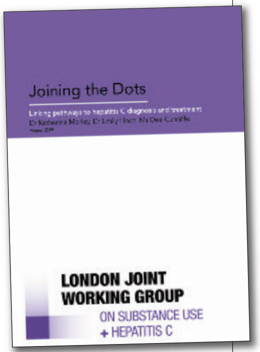
## STUBBED OUT

**JUST 16 PER CENT OF SECONDARY-SCHOOL PUPILS HAVE SMOKED TOBACCO compared to almost 50 per cent in 1996, according to the latest figures from NHS Digital. Almost a quarter have tried drugs, however, while 17 per cent drink alcohol at least once a month – rising to almost 40 per cent of 15-year-olds. Half of the young people who had recently drunk, taken drugs or smoked cigarettes experienced 'low levels' of happiness, the report adds.** *Smoking, drinking and drug use among young people 2018 at digital.nhs.uk*

## CHALLENGING ISSUES

**VULNERABLE ADULTS' ALCOHOL USE IS BEING 'MISSED OR POORLY MANAGED', according to a report from Alcohol Change UK, with the mismanagement of severe alcohol problems among people with complex needs increasing their risk of harm and even death. All professionals working with alcohol-dependent people should be fully trained to recognise the 'complicated role that alcohol plays in adult safeguarding', says the document, and stresses that a person's refusal of care needs to be 'constantly challenged'. The refusal of alcohol treatment should not lead to someone being deemed beyond help, it says, and treatment services may need to adapt their models, for example through the use of home visits.** *Learning from tragedies: an analysis of alcohol-related safeguarding adult reviews at alcoholchange.org.uk*

## SHARE AWARE



**MANY PEOPLE DELIVERING HEPATITIS C TESTING** or treatment do not understand which data can be shared or with whom, according to a new report from the London Joint Working Group on Substance Use and Hepatitis C (LJWG). Clear guidance and training is needed to ensure progress towards eliminating hep C, says *Joining the dots: linking pathways to hepatitis C diagnosis and treatment. Report at ljwg.org.uk. See news focus, page 8*

## DRUG DELUGE

**THE PRISON SERVICE RESPONSE to the 'deluge of drugs flowing into many prisons' in recent years has been slow and 'neither robust nor sophisticated', according to the chief inspector of prisons' annual report. Last year had been another 'deeply troubling' year for parts of the prison estate, with many establishments still 'plagued by drugs, violence, appalling living conditions and a lack of access to meaningful rehabilitative activity', the report states. The government has since promised a 'crime crackdown' in prisons, with 'airport-style' security to tackle smuggling of drugs and weapons. 'We cannot allow our prisons to become factories for making bad people worse,' said Prime Minister Boris Johnson.** *HM chief inspector of prisons' annual report for 2018-19 at www.justiceinspectorates.gov.uk*

## NEXT LEVEL

**THE FIRST POST-INTRODUCTORY LEVEL INTERPERSONAL GROUP THERAPY COURSE IN THE UK** has been launched by Action on Addiction. Based on a collaborative adult learning model, the practice-based course is designed to equip people with a full understanding of how interpersonal group therapy can be effective in facilitating character change. Teaching takes place one Saturday per month in Warminster from 16 November onwards. Meanwhile, applications are open for the foundation degree in addictions counselling at University of Bath, offering a mixture of academic study and work-based learning. *For more information email training@actiononaddiction.org.uk*

# AGENTS OF

We urgently need to become activists once more, argues **Nick Wilson** in his contribution to The Vision Project

**The UK's well-deserved reputation for developing gold standard harm reduction services was the envy of many countries around the world**. From modest beginnings in the 1980s and an extraordinarily passionate and committed harm reduction community, was crafted the level of activism which ultimately brought harm reduction into the UK's healthcare mainstream.

Credit must also be given to the UK government who at this time, and faced with the emerging 'AIDS epidemic', committed protected funding to support the growth and roll out of harm reduction services, most notably the provision of needles and syringes for people who inject drugs. Rates of HIV in the UK today (about 1 per cent of people who inject drugs) are among the lowest in the world and testament to this partnership of activism and political pragmatism.

From the late '80s the UK began to refine effective skills around engagement and interventions to reduce harm among people who inject drugs. The four cornerstones of harm reduction – needle and syringe provision, substitution therapy and methadone, treatment for hepatitis C and HIV and the prevention and reversal of overdose – established our role as agents of behaviour change within this inclusive, non-judgemental, low-threshold environment.

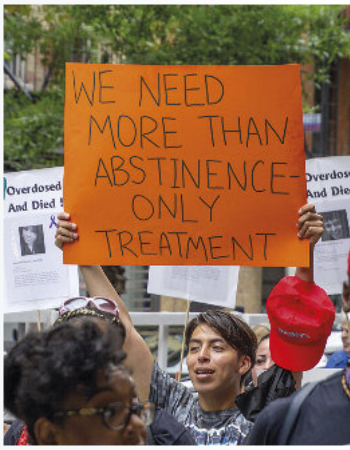
We have been effective at reducing the risks associated with injecting drug use and developing initiatives which deliver some of the most cost-effective health interventions of any kind. It is estimated that for every £1 spent on harm reduction, £4 is delivered in return in health and social gain. This was achieved by tenacity, commitment, compassion and years of activism at a time when our communities would rather see people who inject drugs locked up rather than understood, treated and supported.

However, despite achieving the inclusion of harm reduction within mainstream healthcare, the attitudes of the public have not changed towards people who inject drugs. Look beneath the thin veneer of acceptability for harm reduction in our communities and there remain the same pernicious and ignorant views about drug use which are ill-informed but ensure that people who use drugs remain some of the most marginalised in our society.

This is due in part to the UK government's insistence that drugs and drug use remain illegal and the fear and ignorance within our society that leads many to believe people who use drugs should be locked up rather than helped. Society does not see them as worthy of compassion and healthcare and resents 'their taxes being spent' on injecting equipment and treatment. It's also due to the failure of a truly representative and sustainable model of a service user involvement movement, which would have helped ensure service users' views and rights were central to the planning, funding and commissioning process at both the political and service delivery level.

## A PERFECT STORM

Sadly, since 2010, England has systematically disinvested in harm reduction. The political firestorm debate of 2008 saw the abstinence model of intervention win out over harm reduction, and the government's new drug policy in 2010 saw a political shift away from harm reduction. This occurred at the same time as a move in the commissioning responsibility for drug services from the then primary care trusts to local authorities, just as the authorities ran out of money. The ring-fencing of funding for HIV, which supported drug services, disappeared and harm reduction had to start competing for funding against a range of other worthy causes within public health.



There is no doubt that many people have benefited beyond their hopes from the opportunities delivered by the recovery model, but many people who use drugs are so much worse off. In the UK we are experiencing an increase in homelessness, and drug-related deaths are higher than they have ever been. We have now also had the worst HIV outbreak in 30 years, a fact which outside of Scotland hardly anyone knows or talks about.

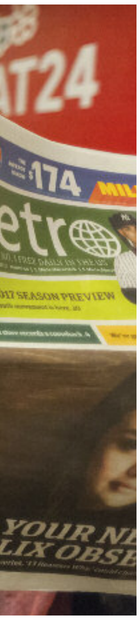
## DIMINISHED SERVICE

Many harm reduction services that traditionally provided a front door into treatment services and, no less importantly, a safety net for people who couldn't manage the treatment options on offer, now provide little more than the distribution of injecting equipment. The systematic disinvestment in harm reduction in England has left many people alone, isolated and vulnerable, without skilled harm reduction workers to do what they always have: engage, support and save lives.

A recent exchange on social media quoted a triage discussion with a new client registering at a needle and syringe programme provided by a large national charity: 'Whilst going through the triage paperwork to register he was asked his preference regarding administration of substances. He told the worker he was an IV user. The worker didn't know what that was, so he expanded saying he was an intravenous user. The worker still didn't know what that meant.'

Does this represent what happens in most drug services? Of course not, but it

# CHANGE



> ‘We have been effective at reducing the risks associated with injecting drug use and developing interventions which deliver some of the most cost-effective health interventions of any kind.‘

does happen and it absolutely should not. So many drug services now have staff covering the needle and syringe programme who do not have the required knowledge, skills or even, in some cases, the appropriate attitudes to engage with some of the most marginalised and vulnerable people in our society.

In this environment, good quality harm reduction cannot happen and we have little hope of reducing or ending the harms and social isolation of drug users until there is enough political will to develop a drug policy which truly reflects the value of human life. Naloxone is not the answer to saving the lives of people who use drugs. Harm reduction is, of which naloxone is one important component.

## THE PROPER SUPPORT

We must celebrate the commitment and compassion of those who work in our field and properly educate, train, mentor and support them. This doesn’t have to cost the earth – it’s not a financial issue, it’s a cultural one. In a world increasingly dominated by pharmacy provision of syringes, we appear to have forgotten how to like and respect people who use drugs. If we lack positive enthusiasm and optimism, what right do we have to expect this in others?

Services must properly support our amazing colleagues to once again create the culture of acceptance and engagement, save more lives and improve the health of people who inject drugs. We need to reimagine how harm reduction can work in this austere climate and, yes, maybe this also means we need to rediscover a new style of activism to once again make a difference by keeping people who inject drugs alive and well.

We must also engage with our communities in a way that encourages them to reframe their understanding of drugs and the people who use them. We have to challenge attitudes and break down the barriers that prevent society from feeling compassion, understanding and acceptance for people who make life choices that can carry risk.

We accept people who make life choices that lead to heart disease, diabetes, respiratory disease and cancer, yet condemn people who inject drugs for ‘wasting precious health resources’.

This health inequality is perverse and is perpetuated by a political policy which continues to classify people who inject drugs as criminals, fails to support harm reduction and does nothing to challenge society’s perpetual exclusion of people with genuine health needs. In the absence of any political will to address this, our only hope is that the field can become activists once more and bring about the change we need.

We did it before; we can do it again.

***Nick Wilson is from Exchange Supplies, a social enterprise specialising in harm reduction equipment. The Vision Project published this piece on 28 July to coincide with World Hepatitis Day.***

## A NEED FOR VISION

Developing Health & Independence (DHI), a West of England based social exclusion charity are marking their 20th anniversary this year with The Vision Project. This series of articles, podcasts and events is exploring the question of how they can achieve their vision to ‘end social exclusion by ensuring that everyone has their basic needs met and is able to thrive by contributing to the richness and wellbeing of their community’. All articles and podcasts can be found at ***www.dhi-online.org.uk/vision-project*** and you can sign up to get latest updates on the project at ***www.dhi-online.org.uk/newsletter***.

# THANKS FOR SHARING

Testing and treatment for hep C may have improved, but data sharing is lagging dangerously behind, warns a new LJWG report

**NHS ENGLAND'S TARGET DATE TO ELIMINATE HEPATITIS C IS 2025** – five years ahead of the World Health Organization's 2030 target. It's an ambitious objective, and one that the NHS is confident it can meet. 'We are working, we are curing people, the strategy is being successful,' its clinical lead for hep C, Dr Graham Foster, told last December's *Seven years to elimination: the road to 2025 conference* (*DDN*, February, page 12).

Delegates at the same event, however, also heard the results of an evaluation project by King's College's National Addiction Centre on operational delivery networks (ODNs) meeting their hep C targets. One of the main obstacles identified was missing data, frequently the result of providers having different electronic patient record systems – an 'endemic problem across the NHS', according to the National Addiction Centre's Dr Katherine Morley.

> 'It almost seems as if people feel it's better not to share so you don't get in trouble.'
>
> Dee Cunniffe

### THE IMPORTANCE OF EFFECTIVE DATA SHARING

Now a new report from the London Joint Working Group on Substance Use and Hepatitis C (LJWG) is highlighting the importance of effective data sharing processes if the elimination target is to be met. Treatment and testing for hep C has improved dramatically in recent years, but with more diagnoses happening at different locations – drugs and outreach services, GP surgeries, prisons – it's crucial that organisations have systems in place that can process and share patient information efficiently.

Eradicating the virus will only happen if the many services engaged with people with hep C 'join up their data systems so that people who are diagnosed can progress quickly and easily to treatment and care', said LJWG co-chair and clinical director of South London and Maudsley NHS Foundation Trust's Central Acute and Addictions Directorate, Dr Emily Finch. While joining up data systems might sound fairly simple, the reality is 'not straightforward', the report states. Different organisations have different IT systems and different processes for sharing their diagnoses with ODNs, treatment providers and Public Health England (PHE). 'These issues are technical but they are absolutely vital in making the system work for patients,' it stresses.

### DISENGAGEMENT FROM TREATMENT

Most hep C testing is still carried out by community drug and alcohol teams, and – while some providers are moving towards point-of-care testing – is usually outsourced to either hospital or commercial laboratories. While local authorities are responsible for commissioning testing in drug services, the responsibility for testing in GP services lies with clinical commissioning groups (CCGs). Responsibility for treatment, meanwhile, lies with secondary care providers and the ODNs, with NHS England responsible for commissioning the drugs used in treatment. This array of providers and commissioners means there's no single data controller, and makes an easily navigable pathway from diagnosis to completion of treatment vital.

One key factor is the very real risk of disengagement from treatment, co-author and LJWG policy lead Dee Cunniffe, tells *DDN*, making it 'absolutely critical' that referral is as fast as possible. 'People with really complex needs often find services difficult to access – that's a given. The more complex the needs, the more difficult it is for them to navigate multiple venues, multiple appointments, different people. Really what you're looking for is point-of-care testing and getting your results as quickly as possible at a place you attend regularly.'

### EXPLICIT CONSENT

While all the care providers interviewed for the report had their own electronic medical record (EMR) systems in place, specific systems for storing, accessing, and updating them varied 'even within sectors', it says. EMR systems used by drug and alcohol teams, GPs and hospitals were all different, and even drug teams within the same umbrella organisations often used different EMRs. Data sharing is also not usually automatic between these systems – for example, between a hepatology department and a drug service.

It's not just the systems that are the issue, however. Many people involved in testing and treatment also remain in the dark about which data can be shared, who it can be shared with, and when explicit consent is required to share it, the document states. This confusion has been exacerbated by the introduction of General Data Protection Regulation (GDPR) and the 2018 Data Protection Act.

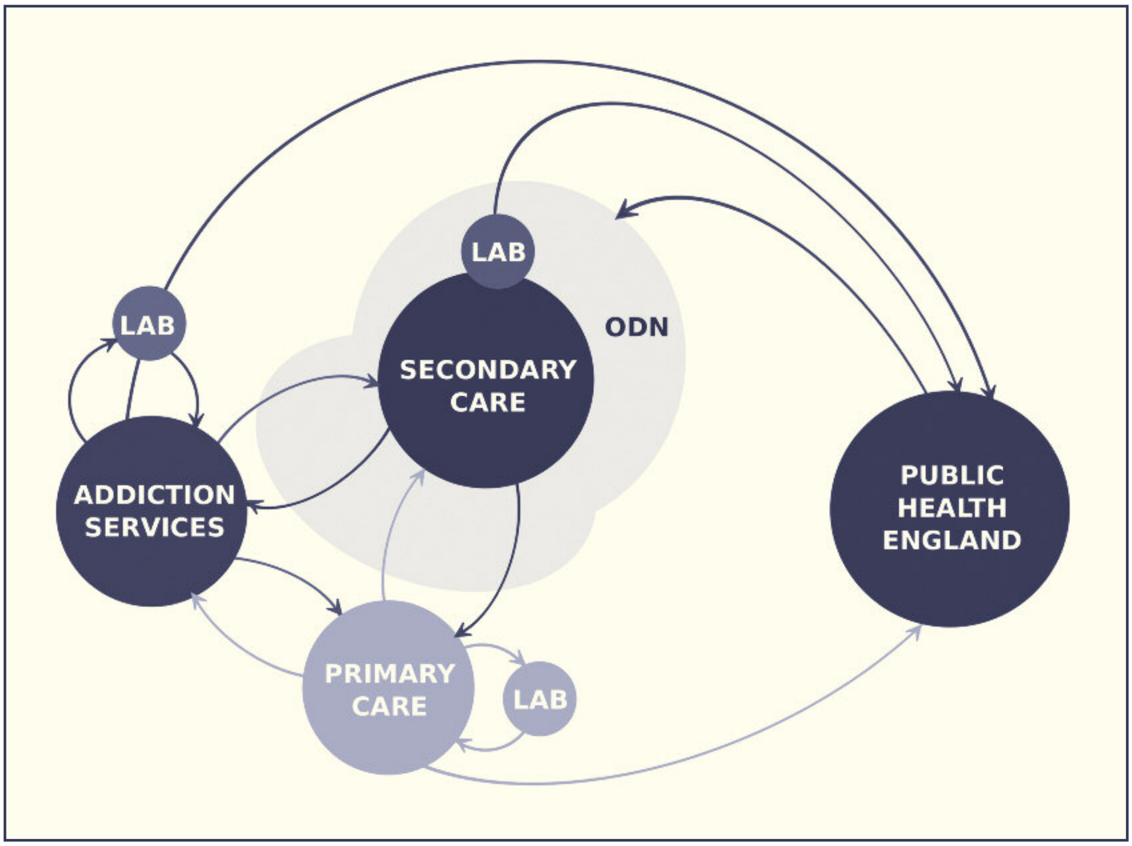
### A CLEAR UNDERSTANDING OF REGULATIONS

Regulations regarding data sharing were originally set out in the Health and Social Care Act 2015, which specifies that health and adult social care organisations have a

### DUTY TO SHARE

Data sharing without explicit patient consent is permissible under GDPR where sharing is for optimal patient care as this is a public task and it is potentially problematic for other care providers not to have this information. There is essentially a 'duty to share' where this is for patient care and when it could be reasonably expected by patients as part of that care.

More on hepatitis C at
www.drinkanddrugsnews.com



**Information sharing pathways between care providers involved in hepatitis C testing and treatment** *(left)*: The arrows indicate the flow of information to and from the different care providers that is needed to ensure successful testing and completion of treatment. *Source: ljwg.org.uk*

legal obligation to share patient information with each other in order to provide the best care possible. While GDPR and the Data Protection Act do not actually alter the requirements of this in terms of sharing data to facilitate care, many people are unaware or unsure and tend to very much err on the side of caution.

Clinicians, information governance specialists and Caldicott Guardians – the people responsible for protecting the confidentiality of personal health and care information and ensuring that it's used properly, and which all NHS organisations are required to have – were all interviewed for the report. While the Caldicott Guardians and information governance personnel had a clear understanding of the basis on which data could be shared, this had not 'penetrated all levels of clinical practice', the report found. Many people believed that obtaining written consent from patients was the 'best' – or only – basis on which data could be shared.

'It wouldn't take much to get those messages out there'

### SHARING DATA AS PART OF CLINICAL PRACTICE

This is 'at odds with' the Health and Social Care Act and GDPR, the report points out, which 'create an obligation to share data for patient care and provide a legal basis for doing so that does not require explicit patient consent'. This confusion and anxiety about what sharing is or isn't permissible means that information often ends up not being shared at all, even when it would clearly be in the best interests of patients.

'When we spoke to the Caldicott Guardians and the information governance people the overall feeling was, "We don't understand why people are doing this,"' says Cunniffe. 'People need to talk to their Caldicott Guardians and IG leads and ask these questions. I think senior managers could do with doing it as much as anybody.'

The focus should not be on consent as the 'sole legal basis for sharing and processing patient data,' the report continues. 'GDPR has specific allowances for sharing data as part of clinical practice, both in terms of delivering care and administrative work, that do not require explicit consent.' LJWR wants to see the development of clear guidance and training, particularly for drug service staff, around when explicit consent is needed, which data can be shared, who it can be shared with and under what circumstances. This could be provided by PHE or the ODNs.

'Ever since the LJWG was established there's been times when people will say "we can't share that", then you'll go to another area and they will,' says Cunniffe. 'When we started up our pharmacy testing project (*DDN*, June 2018, page 5) we found that people are just really edgy about sharing data with each other. It almost seems as if people feel it's better not to share so you don't get in trouble.'

Ultimately, a lot of these issues could be solved by effective training, she says. 'I think there's a real need for organisations to stand up and tell their staff, "Look, you're OK – you can do this." It wouldn't take much to get those messages out there. But we need organisations to take a lead on it.' **DDN**

| OBSTACLE | RECOMMENDATION |
|---|---|
| *Lack of clarity regarding sharing patient data under GDPR* | Clear guidance and training for care providers, particularly CDATs, regarding:<br>• when explicit consent is, and is not, necessary for data sharing;<br>• which data can be shared;<br>• who data can be shared with, and under what circumstances.<br>This could be provided by ODNs and/or PHE. |
| *Lack of informatics to facilitate data sharing* | ODNs and commissioners should work together to find informatics solutions to facilitate data sharing between local care providers, including third sector organisations where relevant. |
| *Lack of resources to support HCV testing and treatment* | Additional support for hepatology outreach, particularly in CDATs but potentially also in other contexts such as pharmacies. |

**Recommendations** *(left)*: In light of the findings from this report, LJWG make three recommendations for potential strategies to overcome the obstacles they have identified. *Source: ljwg.org.uk*

# A PRESCRI FOR PAIN

## Paul was prescribed OxyContin after an industrial injury. But that was just the start of his problems

My name is Paul. I'm 51 and live in a small market town in the Peak District. I enjoyed a happy childhood and walked straight into a full-time job after school. At 18 I joined a local concrete manufacturing company and spent around ten years hand stacking very heavy paving slabs.

One morning at work I injured my back. This was in the days where awareness around health and safety issues was far lower than today, and I had some physio and returned to work a few days later. Over the following years I was promoted many times, but continually experienced problems with severe, debilitating lower back and neck pain.

Around ten years ago I was diagnosed with degenerative disc disease after MRI scans showed damage to five discs in my back and two in my neck, all believed to be caused by the heavy manual job I did for years. Numerous injections at the pain clinic offered no relief and I was eventually prescribed OxyContin.

Each time I visited the doctor the dosage was increased as it was no longer giving me any pain relief, until I was eventually prescribed 800mg per day – but taking 1,500mg per day. I would wake up around 2am then spend the rest of the night thinking of excuses for how I could collect my prescription early. OxyContin was the last thing I thought about at night and the first thing in the morning. At this point, I was no longer taking this amount of OxyContin to relieve the pain – I was taking it simply in order to function. I realised I had a serious problem.

One tablet was supposed to last a full 12 hours – I was taking my dose every couple of hours. However I kept telling myself I couldn't possibly be an addict, as I had been prescribed this by my doctor. There were times when I would run out because my GP was on holiday and the locum or other doctors refused to prescribe such a high amount. I would then suffer full-blown withdrawal until I could pick up my next prescription.

Around this time I was involved in a car accident. While lying in the hospital bed the nurse asked me if I was taking any medication. When I told her 800mg of OxyContin per day, but actually almost double that, she said, 'You must mean 80mg.' I replied no, and my partner confirmed the amount.

I got another, better-paid job but was still taking around 1,500mg per day and was eventually let go. Sitting at home wondering what I was going to do, I started to replay things in my mind – what if that car accident was actually my fault due to the amount of OxyContin I was taking? What if I believed I was doing a good job but actually wasn't and that's why they let me go? I decided I'd had enough and wanted my life back. I made an urgent appointment with my doctor and said I wanted off all the OxyContin.

I was then told that there had been several meetings held about me, and my doctor had been reprimanded by other GPs at the surgery over the amount of OxyContin I had been prescribed over such a long period. I was then referred to my first drug clinic, where the drug worker said they couldn't help me as it wasn't heroin. Another clinic told me the same thing.

I moved back to the small town I grew up in and registered at the local GP surgery.

The doctor drew up a taper plan that I was determined to follow. Over the following months I stuck to it and was doing really well, managing to reduce from the 1,500mg down to the actual prescribed level of 800mg, then gradually further until I'd dropped down to 320mg per day.

Findings from the 2014/15 Crime Survey for England and Wales examines the extent and trends in illicit drug use among a nationally representative sample of 16 to 59 year olds resident in households in England and Wales. In 2014/15, for the first time the survey included questions relating to misuse of prescription painkillers (use of prescription analgesics by those for whom they are not prescribed). Findings include:

- *Overall, 5.4 per cent of adults aged 16 to 59 years had misused a prescription-only painkiller not prescribed to them*
- *7.2 per cent of 16 to 24 year olds had misused a prescription-only painkiller in the last year, while 4.9 per cent of 25 to 59 year olds had done so.*
- *People with a long-standing illness or disability were more likely to have misused prescription-only painkillers.*
- *Misuse of prescription painkillers is distributed more evenly across the general population than the use of illicit drugs*
- *Misuse of painkillers was similar in both rural and urban areas*

More on prescription drugs at:
www.drinkanddrugsnews.com

# IPTION

> ‘I was then referred to my first drug clinic, where the drug worker said they couldn’t help me as it wasn’t heroin. Another clinic told me the same thing.’

However, this is where my journey to hell began, going around in circles from doctor referrals to drug clinics and pain clinics, being told the same old story and referred back to my GP. I was suicidal at this point. I’d done so well to reduce my dose, but could no longer see any way forward. Eventually I contacted Release who got one of the drug clinics to agree to treat me, and after an agonising few months, starting on a minimum dose of 30ml of methadone that didn’t even hold me for two hours, they eventually got me to a dose of 105ml where I was stable and no longer going through horrendous withdrawals. I reduced the methadone over many months until I finally became drug-free.

However in 2016 I was diagnosed with severe ‘central’ sleep apnoea. My driving licence was revoked and I was told after blood tests that my testosterone level was zero. I also have peripheral neuropathy from pernicious anaemia, where it is painful to walk due to nerve damage in my feet, and I still have the degenerative disc disease in my back. However, I’m looking at alternative relief rather than the legal heroin I was given that almost took my life.

My main passion and purpose now is to educate everyone about how long-term opiate use destroys lives and actually makes pain so much worse in the long term. Opiates do have a very important role to play in pain relief, but only in certain situations and only for the short term, prescribed and monitored very closely. Even though I was lucky enough to beat my addiction, I am now having to deal with the long-term health effects. Not only did my addiction take everything I had, it also greatly affected the people who I love most.

If by telling my story and raising awareness of what I experienced I can save even one person from suffering what I went through, it will have been worth it.

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## POST-ITS FROM PRACTICE

# BUT DOC... I’VE BEEN ON THEM FOR YEARS

Addressing long-term prescribed opioid use requires an individualised approach, says **Dr Steve Brinksman**

**THERE HAS BEEN A CONSIDERABLE INCREASE** in the focus on prescribed opioid painkillers lately, and with good reason given the alarming statistics on overdose deaths from the US alongside massive increases in prescribing in the UK.

This has resulted in improved awareness of the risks associated with these drugs, and hopefully means that careful consideration will be given before using them for non-cancer chronic pain and fewer patients will continue them where there is no substantial benefit. However we are still left with a large number of patients who have been prescribed these drugs for many years, and that brings us to the potentially thorny issue of de-prescribing. How do we best approach this?

> ‘An individualised approach agreed between the prescriber and the patient seems... the best compromise’

Some may advocate reducing and eventually stopping these drugs for all in whom there is no sizeable reduction in pain, but how to assess that? For some patients, years of taking them have blurred the line between benefit, tolerance and dependence. Auditing prescribing data can be a good start, and writing to patients and flagging notes to discuss at medication reviews are useful tools as well.

Richard is a case in point. He is 70 and has been taking opioids for many years, originally for osteoarthritis that developed in his early 50s. He has a history of depression and anxiety, was alcohol dependent for many years, and cares for his wife who is slowly dying from severe COPD.

As well as his opioids he also takes regular diazepam, although over the years the dose of this has come down. He is currently on a 100mcg fentanyl patch, co-codamol and Oramorph. He freely admits that he is dependent on these but as they were started by a doctor, he doesn’t feel he should have to stop them. I suspect this is a common scenario.

We had a lengthy consultation and I was able to explain that medical opinion was changing, that these drugs were now felt to be less effective than we used to believe, and that decreasing liver and kidney function could mean he was at greater risk of overdose as he got older. We also discussed the impact on his wife if he wasn’t around to care for her. Following our conversation we agreed that we would reduce his fentanyl from 100 to 87mcg and in six months to 75mcg, when we would discuss the situation again.

This probably wouldn’t be enough for the aggressive de-prescribers, but as a GP I can hopefully take a pragmatic long-term approach. It would be better if the situation had never arisen. However it has, and an individualised approach agreed between the prescriber and the patient seems to my mind the best compromise.

*Steve Brinksman is a GP in Birmingham, clinical lead for SMMGP and RCGP regional lead in substance misuse for the West Midlands*

# CRISIS POINT

Last year had the highest number of drug-related deaths on record – 4,359 people, according to the Office for National Statistics (ONS). What should we do to reverse this appalling trend?

## URGENT MEASURES

First, people who use opiates like heroin need easy access to quality treatment in their own communities. This means the right dose of a replacement medication and an experienced key worker to support and listen to them.

Second, we need to invest more in community outreach. Many local services have faced cutbacks and the reality is that outreach services barely exist anymore.

Third, we need a national push to promote the overdose reversal drug naloxone. It is a safe, effective, life-saving tool and we need to get people trained and carrying naloxone all over the country.

Fourth, the rise in cocaine deaths shows treatment services need to do more to reach out to this group.

These are crisis measures. They are urgent and necessary. But we will only make real progress if we tackle poverty and disadvantage in our communities.
*Mike Dixon, chief executive, Addaction*

## STRONGER FOCUS ON PREVENTION

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

FACULTY OF PUBLIC HEALTH

**We believe that drug policy should be guided by the best available scientific evidence, rather than by ideology or political expediency and this includes an evidence-based approach to drugs classification. We call for a stronger focus on prevention and the root causes of problematic substance use. Interventions should be delivered by a skilled workforce in collaboration and consultation with peers in recovery and professionals from other areas such as primary care, mental health, housing and employment support. Drug users must also receive equitable access to health services to improve their physical health.**
*Royal Society of Public Health and Faculty of Public Health*

## EVIDENCE-BASED TREATMENT

Long- term heroin users with poor health, who frequently use a cocktail of different drugs and alcohol, 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 is also key.
*Jay Stewart, director for public health and substance misuse, Turning Point*

## A PUBLIC HEALTH CRISIS

**We know that drug-related deaths are linked to age and complicated by health conditions. Poverty, deprivation, homelessness and mental health conditions all increase the chances of a life lost to drugs. That is why we need investment in substance misuse services that support people to improve their physical and mental health.**

**Working with our partners, we are fully committed to offering comprehensive care and supporting our service users to be healthier and happier. This includes providing medical help and opportunities for housing, volunteering, training and meaningful work.**

**We continue to prioritise the national distribution of life-saving naloxone kits. In the last year alone, more than 1,500 lives have potentially been saved through naloxone.**

**This is a national public health crisis and action is needed. Our message to any person or organisation that can prevent another drug-related death is simple – we are ready to work with you.**
*Mark Moody, chief executive, Change Grow Live*

> 'Our message to any person or organisation that can prevent another drug related death is simple – we are ready to work with you.'

## LOSS OF HARM REDUCTION TALENT

NHS
Substance Misuse
Provider Alliance

This report further emphasises the need for a focus on effective harm reduction interventions as well as a need to address key stresses on the treatment system, such as naloxone prescribing and the overall capacity of the workforce which has experienced a significant loss of talent, particularly harm reduction specialists.

It is clear that the ability of the treatment system to respond is being stunted by ongoing budget reductions, instability in commissioning arrangements and the overall budget available. When will government draw a line in the sand and decide enough is enough around drug- related deaths?
*NHS Substance Misuse Providers Alliance (NHS SMPA)*

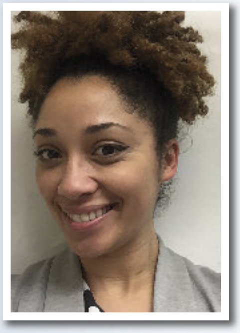
## FOLLOW THE EVIDENCE!

**With this condition, as with many other medical conditions, we need to follow the evidence and not what people would prefer to be true. The evidence shows us that opioid substitution treatment and other forms of treatment that go alongside decriminalisation, such as has been done in Portugal – increasing welfare, reducing punishment and providing public health services – have been shown to reduce drug-related deaths, and that's what we should be doing.**

**Most of the people who suffer from chronic drug use have had very difficult lives including bereavement, trauma, abuse and neglect. Very few of those people who have been using heroin for a long time do that out of choice – they do it because they are caught in a situation where heroin use is the only way to reduce their pain.**

**[For] people that have got into problematic patterns of heroin use, the most effective thing we can do is provide them with good treatment and stop punishing them.**
*Alex Stevens, professor in criminal justice and joint chair of ACMD, speaking on BBC Radio 4*

CLINICAL EYE



# CRUMBLING UNDER PRESSURE

What are we doing to support nurses' health, asks **Ishbel Straker**

**IT WAS WITH GREAT SADNESS THAT THE KEYS TO CITY ROADS DETOX UNIT WERE HUNG UP FOR THE FINAL TIME EARLIER THIS YEAR** – a service with a legacy of over 40 years of supporting drug and alcohol users to reach their goals. A staff team of exceptionally passionate people who genuinely had a heart for their clients and who steered them towards success at every opportunity, a team who had embraced changes where others may have crumbled under the pressure of 'this is how it has always been done' and did everything in their power to uplift this service in the face of political adversity.

I was interested to see in the August issue of the *Nursing Standard* an article discussing the NHS England data of almost 7,000 full-time equivalent days sick leave because of drug and alcohol issues. The majority of these issues were related to alcohol, with staff using it as a coping mechanism to manage stress and anxiety. The solution wasn't clear, other than staff needing more support in some form.

This data was between Oct 2017 and Nov 2018 and I have neither seen nor heard a whisper of a measurable response. I have watched staff crumble under pressure throughout my career and it is never a surprise when a substance is brought into the mix. I have seen colleagues become mentally unwell and I have attended funerals of those who have committed suicide, yet the approach seems to never change and surprise is a first response.

With the closure of City Roads and one less place in the country to support such people, I find myself trepidatious about what NHS England may have up their sleeve and would like those reading this from varying organisations to consider how they support their staff – not just with treatment, but to have the confidence to come forward.

*Ishbel Straker is a clinical director, registered mental health nurse, independent nurse prescriber and board member of IntNSA*

## LETTER
## STRIKING A BALANCE

Steve Rolles makes some valid points in his response to my letter (*DDN*, July/August, page 12), and I'm encouraged by the fact that he says many issues around legal regulation are tricky, that challenges exist, balances need to be struck, and that there's 'no perfect answer'. I've always been in favour of decriminalisation, and I'm open to hearing a well-argued case for legalisation and regulation as well.

What antagonises me is the unquestioning certainty of much that's written on this subject by many media commentators – 'war on drugs' bad, legalisation good – as if it were some magic bullet that would miraculously end all drug harms and put the world's organised crime groups out of business overnight. So it's nice to hear something a bit more nuanced (and it goes without saying that Transform know considerably more about this subject than your average columnist).

He's also right to say that mephedrone's popularity had a lot to do with MDMA shortages, although evidence does suggest that a significant proportion of its users were people who hadn't really taken many drugs before and did so because it was legal. One of my points he doesn't address, though, is the question of the US – a massive increase in legal opioid prescribing, coupled with a massive increase in opioid-related deaths.

*Molly Cochrane, by email*

# MEDIA SAVVY

The news, and the skews, in the national media

NEWS
VOTERS CHOOSE POLITICIANS WHO REPRESENT THEM SHOCK

'The uncomfortable truth might be that we, the electorate, are responsible.'

**THE INCREASE IN DRUG-RELATED DEATHS** hasn't suddenly happened, deaths have been rising significantly for years. There has been ample opportunity to think about how to reverse this horrendous trend. And unusually, we know how to do it. The evidence has been collected and made available to ministers... So if it's not a lack of evidence, something else must be holding back politicians from tackling the rise in drug-related mortality. It's seductively simple to point out the failings of politicians on this issue. But they instinctively follow public opinion rather than shape it. So the uncomfortable truth might be that we, the electorate, are responsible.

**Ian Hamilton, *Independent*, 15 August**

**FEW EXPERTS** consider that criminalising vulnerable and marginalised people who inject drugs is an appropriate response. The UK government should stop politicking about being 'tough on drugs' and act urgently to stop the harm to which its policy contributes. Decriminalisation of personal drug use allows interventions such as safer injecting rooms and drug testing where appropriate. It also enables gathering of evidence. What is already clear is that moralising about perceived intrinsic wrongs in taking drugs and blaming or punishing patients for having drug use disorders are not effective or ethical ways to reduce harm.

**Richard Hurley, *BMJ*, 8 August**

**MOST ADDICTION SERVICES** are not properly connected to wider health and care teams, so people are bounced between addiction and mental health services or fall between the gaps in both. It's not uncommon for a patient to be excluded from mental health services due to having drug or alcohol use disorder but not be able to access addiction services because they have an untreated mental illness. This represents a lost opportunity to improve outcomes for patients, reduce the harm to individuals and their families, as well as a staggering waste of limited resources.

**Julia Sinclair, *BMJ*, 23 August**

**AS THE SICKLY-SWEET STENCH OF MARIJUANA** spreads ever further across the once-civilised Western world, there is one universal result. There are more crazy people. Some of them are dangerous. Many of them are crazy because they have fried their brains with skunk. Some are crazier still because baffled doctors have added to the cocktail with various poorly understood prescription drugs. But the chances that you will meet such a person grow daily, as our leaders refuse to enforce the laws against marijuana possession. They will grow still more if they are stupid enough to bow to the billionaire campaign to legalise this poison.

**Peter Hitchens, *Mail on Sunday*, 11 August**

# CASE DISMISSED

Mark Harvey / Alamy

## Why are recommendations to improve custody-community transitions being routinely ignored when so many lives are at stake? **DDN** reports

As drug-related death rates continue to rise there is one fact we can be sure of: that newly released prisoners make up a significant number of those who lose their lives – there were 955 deaths of offenders in the community in England and Wales in 2017-18. The few weeks after release pose a particularly high risk.

The reasons for this can be complicated and overlapping – tolerance to drugs has been compromised while chaos is reintroduced. Those who find themselves in custody frequently have mental and physical health problems, all kinds of background trauma, and problems relating to their housing and basic wellbeing – all mixed in with their problem drug use. Leaving prison can mean confusion, uncertainty and overwhelming difficulties with families, accommodation and day-to-day living.

These issues have been well documented over the years, with clear recommendations resulting from reviews such as *The Patel report: reducing drug-related crime and Rehabilitating offenders: recovery and rehabilitation for drug users in prison and on release: recommendations for action*, published by the government in 2010.

But according to the Advisory Council on the Misuse of Drugs (ACMD), the extent to which these recommendations have been implemented is unclear, with little evidence to suggest that they have led to safer practice. In their report, *Custody-community transitions*, released in June, they examined the existing recommendations and, with input from government departments, service providers and charities in the sector, looked at what must change (*DDN*, July/August, page 5).

A look at the 'substantial harms' that contribute to the unacceptable death rate showed that many prisoners were still being released without the certainty of accommodation, increasing their risk of relapse and reoffending. The risk of death post-release was many times higher than in the general population, particularly in the first few weeks – yet naloxone was not being provided routinely to guard against fatal overdose. Furthermore, the opportunity to reduce drug problems in custody was being squandered by the subsequent failure to provide support on release.

In the last ten years a new challenge had also emerged through widespread use of synthetic cannabinoid receptor agonists such as ‘spice’ – adding new health priorities to the continuing efforts to contain blood-borne viruses, particularly HIV and hepatitis C.

So if progress has stalled, where does the failure lie? The picture from the ACMD is of fragmented responsibility and a lack of systematic follow-up. Continuity of care appears to be missing throughout the transition period – the latest PHE data shows that only 32 per cent of people who were assessed as needing treatment on release were having treatment in the community within 21 days.

Many of the deaths resulted from overdose, yet the community policy of maximising access to naloxone (to reverse the effects of an opioid overdose) still hasn’t reached English prisons. Only 12 per cent of prisoners who were previously dependent on heroin left prison with naloxone in 2017-18 because of reluctance among NHS providers to fund it – a situation that could be resolved by funding through national NHS bodies, including NHS England.

With much to tackle, the ACMD has made key among its recommendations the need for a minister, nominated by the Drug Strategy Board, to take over-arching responsibility for improving custody-community transitions for prisoners with complex health needs.

‘The fragmentation of responsibility for implementing the previous reports and recommendations in this area is one of the problems we’ve identified,’ Alex Stevens, co-chair of the ACMD told *DDN*. ‘This is why we’ve recommended that a single minister be made responsible for implementing these recommendations and previous ones, including the Bradley review [2009] and the Patel report [2010].’

While realistic that there could be delays in responding ‘because of all the turmoil politically’, he is hopeful that interest shown last year by Robert Buckland MP could prove useful in terms of continuity, since he has been made minister for justice.

In the meantime, there is much that could and should be done now. ‘Given that, from the spending announcements we’ve been getting from Boris Johnson, austerity seems to be officially over, there’s no reason that money shouldn’t be spent on saving people’s lives by distributing naloxone,’ he says.

## ‘All I want is real help’

**I’ve spent a total of 28 years in custody and over three years in isolation. For years I’ve searched out drugs to give me comfort. When I’m released I find myself scoring and telling lies. I use and it fills that void and temporarily gives me the power to be confident and feel I fit in better. Once it comes to light you’re using, the powers that be recall you and I end up again in deeper discomfort, knocked back again. My hope has gone. The jail’s chocka with drugs and I’m expected to never pick up and use. My family is gone, my mother is in a care home. I’m full of guilt and resentment and all I really want is real help and someone in my corner encouraging me, but I’m falling short of finding good people who get me and know how to help me. The truth is I contemplate suicide a lot.**

***Colin, in a letter to DDN editor***

> ‘If progress has stalled, where does the failure lie? The picture from the ACMD is of fragmented responsibility and a lack of systematic follow-up. Continuity of care appears to be missing throughout the transition period.’

Other recommendations have already been made but need renewed attention – such as the recommendation to change Friday release dates for vulnerable prisoners, to give them a fair chance of experiencing joined-up working between custody and community. ‘This is an odd one,’ says Stevens. ‘NACRO released a report last year arguing for reductions in Friday afternoon releases and the pushback they got from the Ministry of Justice was that if this was working properly, it shouldn’t make a difference what day of the week you’re released on. But all the reports from the inspectorates of both prison and probation show that we do not have a system that’s working properly.’

In some cases, the recommendations are an extension of existing initiatives, such as making sure people have access to universal credit or a chance of employment, along with help to find somewhere to live. ‘There are pilots going on and we’re arguing that these should be accelerated,’ he says. The problem – such as in the case of universal credit, where there is a partnership between the Department for Work and Pensions and the Prison Service – is that they are competing with so many other priorities.

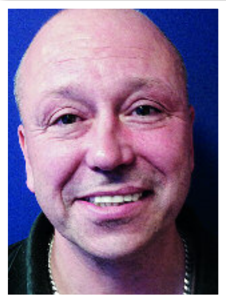
‘We’re arguing that more priority should be given to this population because it’s so highly vulnerable to health problems, but also problematic in terms of its high level of reoffending,’ says Stevens. ‘And so there would be wins for public health and crime reduction if priority was put on meeting the needs and solving the problems of this population.’

And while we wait for the processes of government, what should the treatment community be doing? The ACMD talks about the vital need for effective community pathways and says the ‘main aim’ of the planned reforms to probation should be dealing with offenders in the community – a conclusion built on effectiveness, safety and ‘substantially cheaper’ cost. That surely points to a highly proactive role for community drug and alcohol services?

Stevens recommends looking at the other recent report, by the Ex-Prisoners Recovering from Addiction Group, chaired by Lord Patel. ‘This has developed a blueprint for pathways between custody and community for people with various different types of drug treatment need, including those who have achieved abstinence in prison – a group that’s often let down when they leave prison,’ he says. ‘There are practical steps available in that report.’

Much is being pinned on hopes for a nominated minister, and within that person’s mandate this indicator of progress stands out: ‘reducing the numbers of people who die within four weeks of leaving custody and while under supervision of the probation services.’ Could this be the opportunity to join up the strands of research and recommendation through a clearly defined brief? **DDN**

More recovery activities at:
www.drinkanddrugsnews.com



The sixth annual Recovery Games were the biggest and best yet, says **Stuart Green**

# UPPING THEIR GAME

**Ahead of September's Recovery Month, people from across Britain gathered to celebrate recovery at the sixth annual Recovery Games in Doncaster last month.** The games are the brainchild of Aspire drug and alcohol service, which is run in partnership with Rotherham Doncaster and South Humber NHS Foundation Trust and The Drug and Alcohol Service (ADS).

These games celebrate the achievements, personal journeys and overcoming of challenges faced by people in recovery from a drug or alcohol problem. They provide the opportunity for shared experiences and making new friends and connections with likeminded people who are in recovery themselves. The games symbolise that recovery is possible with the right support and inclusive recovery communities.

> '...this year saw a push to attract more spectators from the general public.'

This year the demand from across the UK to take part exceeded all expectations, with 50 teams from England, Scotland and Wales registering and competing in a day of gladiator-style games and obstacle courses on the ground and in the water. Such was the demand that registrations unfortunately had to be closed early, but plans are afoot to make the 2020 Recovery Games even bigger and better. The rain couldn't dampen the energy and enthusiasm of the competitors and spectators, with just short of 1,000 people attending on the day.

The Recovery Games represents a movement towards inclusiveness, and this year saw a push to attract more spectators from the general public. Families with young children came along and enjoyed the carnival atmosphere, and teams made their own costumes or wore fancy dress to celebrate comradery. This in turn contributed to the build-up of excitement, creating a sense of equality by giving service users, support groups and workers a shared connection and purpose.

The Recovery Games is a mix of celebration, excitement, inspiration and emotion. The minute's silence at the middle of the day was an opportunity for everyone to show respect for the 'fallen warriors' who've lost their battle with addiction. This was followed by the spectacular 'festival of colours' which celebrated being alive – you can watch the film via this link https://youtu.be/2FxPd6yhjL8

The overall winner this year was the 'Greased Lightning' themed team from New Beginnings, a Doncaster based rehab and detox unit run by Aspire. The games were made possible by donations and the proceeds from the sale of merchandise, especially the much-admired t-shirts which have helped secure an important step towards funding the 2020 games.

'This year's games were the biggest and best yet, with the recovery community being stronger and more vibrant than ever,' said event organiser Neil Firbank of Aspire. 'The event is about letting people know that recovery is alive and being nurtured in many towns across the region and the UK. Thank you to everyone who took part and supported this amazing event.'

Tim Young, chief executive of ADS, said the games were a 'great day of celebration. For the first time this year the weather wasn't kind to us and yet the rain did nothing to dampen the magic of the event. If anything this year has added 'the year of the rain' to the legend of the Recovery Games in the same way Glastonbury has its infamous 'year of the mud'. A day of powerful images and emotions, the games once again brought people together to make new connections and reinforce existing ones. The message it sends is clear and loud – "recovery is possible, and fun!"'

Once again it was a fantastic day, exceeding all expectations, with hundreds of people coming together to celebrate and applaud those in recovery from an addiction. The event has become a recognised milestone in the recovery calendar. It sees people with different addictions and health conditions come together, connect, give and learn new skills, but most importantly have fun without the need for substances.

**Stuart Green is service manager at Aspire drug and alcohol service**

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