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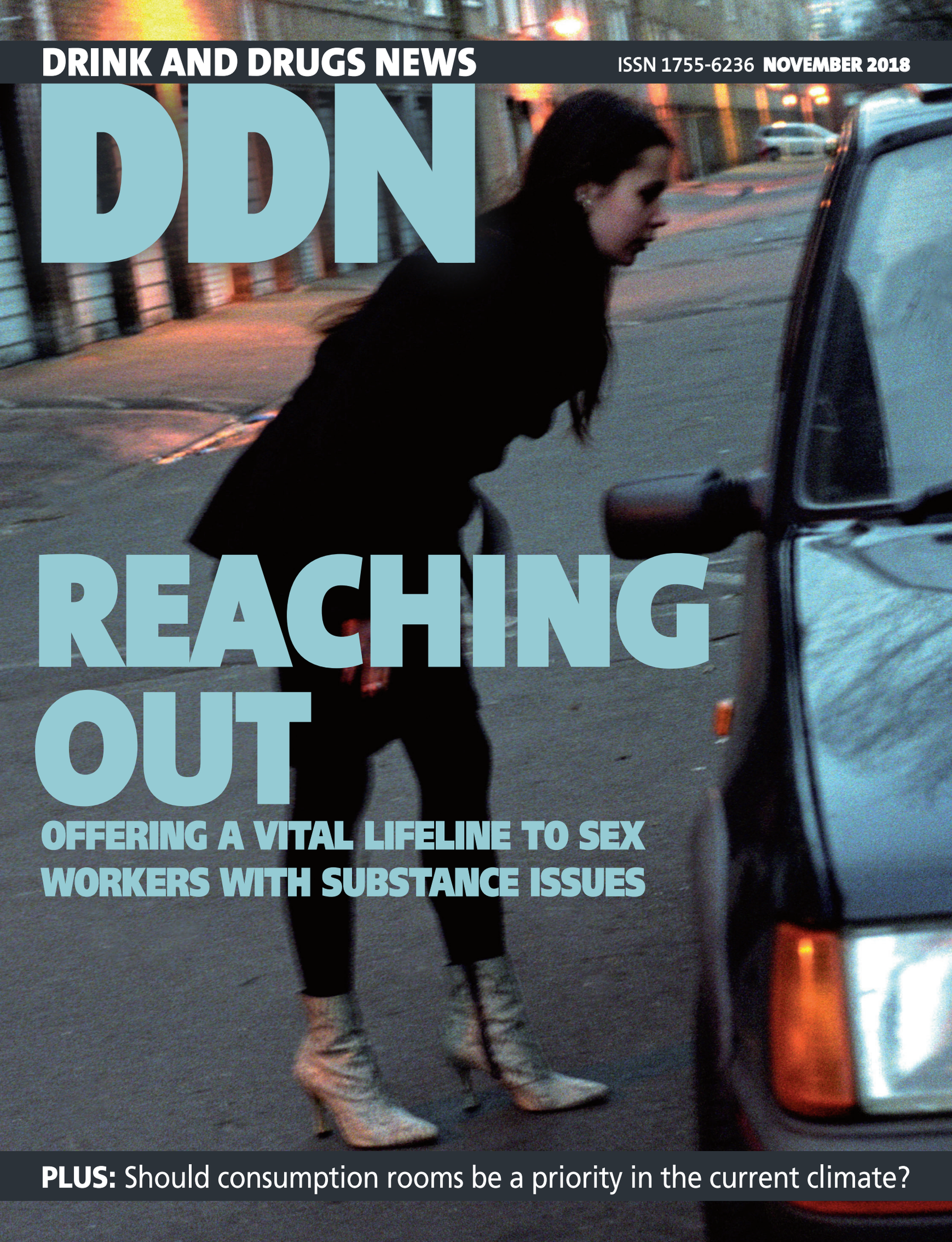

REACHING OUT

OFFERING A VITAL LIFELINE TO SEX WORKERS WITH SUBSTANCE ISSUES

PLUS: Should consumption rooms be a priority in the current climate?

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EDITOR'S LETTER

'Never forget kindness in a results-driven age'

Never under-estimate the power of kindness and a safe space. The SWOP project featured in our cover story showcases the best kind of outreach – meeting people at the stage they're at, offering comfort and safety first and foremost, and then providing the first links to a network of support. It's a way of working, and a set of values, that we shouldn't forget in this results-driven age. Outreach work can be so very undervalued as budget cuts bite, but without projects such as this many people would stay under the radar, scarred by trauma and unable to move on.

As so many of you are striving to do your best with limited budgets it's frustrating to see the spiralling costs of buprenorphine and extremely worrying to think about the effect on clients' stability and progress. The issues behind the price increase are complicated (page 9) but we are in complete agreement with Roz Gittins (page 8) that the situation must be resolved as quickly as possible.

Getting the medication right is among the many things we know will help to prevent drug-related deaths. After listening to the latest ONS figures, participants of a recent parliamentary meeting wanted more information around the personal stories of those who are recorded as statistics (page 12) – and we already know that austerity, homelessness and leaving prison without the right support are major contributors.

We also know that a clear, evidence-based alcohol strategy could make a vast difference to many lives. The charter (page 15) gives measures that would improve treatment, find those in need of support and protect public health – all the while bringing a substantial return on investment and reducing the burden on the NHS. We hope that government will respond to this important document.

Claire Brown, editor

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

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CANNABIS BECOMES LEGAL IN CANADA

ADULTS IN CANADA are now able to legally buy and possess up to 30g of dried cannabis or its equivalent from authorised retailers across the country. After 'extensive consultation' with law enforcement agencies and health organisations, the Canadian government has implemented its legal framework to legalise and regulate access to the drug.

The legislation, which was first announced at the UNGASS in New York in 2016 (*DDN*, May 2016, page 4), aims to 'keep profits from going into the pockets of criminal organisations and street gangs', says the government, and makes Canada the second – and largest – country to legalise the drug after Uruguay (*DDN*, May 2017, page 4). 'The old approach to cannabis did not work,' the government states. 'It let criminals and organised crime profit, while failing to keep cannabis out of the hands of Canadian youth. In many cases, it has been easier for our kids to buy cannabis than cigarettes.'

While the Cannabis Act means that possession of small amounts of the drug is no longer against the law, the government has created a new criminal offence making it illegal to sell cannabis to a minor and has 'added significant penalties for those who engage young Canadians in cannabis-related offences'. It has also toughened laws relating to drink- and drug-impaired driving.

People need to be 18 – or 19, depending on the territory – to legally buy, possess or use cannabis, with legal drugs displaying an excise stamp on the product label. However, anyone either bringing cannabis or cannabis products into – or taking them out of – the country still risks 'serious criminal penalties', the government states, including if the drug is being used for medical purposes. Central and provincial government will also continue public education programmes about the new legal framework, as well as responsible use, health and safety, and the dangers of drug-impaired driving.

'The implementation of this progressive public policy marks an important shift in our country's approach to cannabis,' said justice minister and attorney general, Jody Wilson-Raybould. 'With a strictly regulated market for adults we will help keep cannabis out of the hands of youth and profits out of the pockets of criminals.'

> 'We will help keep cannabis out of the hands of youth and profits out of the pockets of criminals.'
>
> JODY WILSON-RAYBOULD

'While we still have a lot of work to do, we are confident that the more than two years of work that went into this process have resulted in legislation that will help us achieve our public health and safety objectives,' added border security minister Bill Blair.

PREVENTABLE DEATHS

PRISONERS ARE DYING 'PREVENTABLE' DEATHS – particularly as a result of the 'alarming levels of drug abuse in jails', says the prisons and probation ombudsman's annual report. Acting ombudsman Elizabeth Moody said she was 'gravely concerned' at the destructive impact of NPS, with some prisons and their health providers 'struggling to learn' from investigations into deaths. Earlier this year the prison service took over the running of HMP Birmingham from G4S after inspectors found an estimated one third of prisoners using illegal drugs and the highest levels of violence of any local prison (*DDN*, September, page 5).

Prisons & probation ombudsman annual report 2017-18 at www.ppo.gov.uk

> Some prisons and their health providers are 'struggling to learn'.
>
> ELIZABETH MOODY

SKEWED SEARCHES

BLACK PEOPLE ARE NOW NINE TIMES MORE LIKELY TO BE STOPPED and searched for drugs in England and Wales than white people, says a report from Release, Stopwatch and the London School of Economics and Political Science. While the use of stop and search overall has fallen there has been a 'shocking increase in racial disparities in the policing and prosecution of drug offences', says *The colour of injustice: 'race', drugs and law enforcement in England and Wales*. Drugs searches account for 60 per cent of stop and searches, although in some areas the figure is far higher – more than 80 per cent of searches by Merseyside Police in 2016-17 were for drugs.

Report at www.release.org.uk

ADMISSIONS UP

THERE WERE MORE THAN 68,000 HOSPITAL ADMISSIONS DUE TO LIVER DISEASE in England in 2016-17, according to the latest PHE figures, with admission rates 'significantly increasing' every year for the last five years. Rates were 1.7 times higher in the most deprived areas than the least deprived, while the male admission rate for alcoholic liver disease was more than double that of women. Meanwhile, PHE's 'Drink free days' campaign is encouraging women to take more alcohol-free days to reduce their risk of developing breast cancer. 'Many people are not aware that alcohol can cause breast cancer as well as numerous other serious health problems,' said PHE's director of alcohol, drugs and tobacco Rosanna O'Connor.

Liver disease profiles: October 2018 update at www.gov.uk; Drink Free Days at www.drinkaware.co.uk

BUCKING THE TREND

BUCKINGHAM UNIVERSITY intends to ask students to sign a contract pledging not to take drugs, its vice-chancellor Sir Anthony Seldon has written in the *Mail*. 'Old fashioned maybe,' he wrote, 'but never more needed.' The university already invites police and sniffer dogs on to campus to deter drug use.

OVERDOSE ANALYSIS

A new tool looking at overdose deaths and how to prevent them has been launched by EMCDDA. More than 9,000 lives were reported to be lost to drug overdoses in Europe in 2016 – 'and this is an underestimate', says the centre.

Preventing overdose deaths in Europe at www.emcdda.europa.eu

TIME TO PUBLISH 'EVIDENCE BASED' ALCOHOL STRATEGY

A NEW GOVERNMENT ALCOHOL STRATEGY needs to 'lead the way internationally' in reducing the damage caused by alcohol misuse, according to a document from the Drugs, Alcohol and Justice Cross-Party Parliamentary Group and the All Party Parliamentary Group (APPG) on Alcohol Harm.

The *Alcohol Charter* – which is published in consultation with Alcohol Concern, Alcohol Research UK, the Institute for Alcohol Studies and the Alcohol Health Alliance, and backed by 30 other organisations including Cancer Research UK, Blenheim and Adfam – says a new strategy is essential to protect public health, improve support and address alcohol-related crime.

It wants to see the government outline 'concrete measures' to moderate harmful drinking and address England's million-plus annual alcohol-related hospital admissions. Without action, alcohol is set to cost the NHS £17bn over the next five years and lead to 135,000 cancer deaths over the next 20, it states.

An effective alcohol strategy will need to tackle the increased availability of cheap alcohol, provide proper support for dependent and non-dependent drinkers, and 'empower the public to make fully informed decisions' about consumption. It should also be based on the 'evidence of what works' to reduce alcohol harm, as outlined in PHE's alcohol evidence review.

Among the specific measures called for are the introduction of minimum pricing 'following the lead of other home nations', adding a 1 per cent levy to alcohol duties to fund treatment, and mandating local councils to provide a ring-fenced resource for treatment and early intervention services. Councils also need to address the issue of age inequalities in existing services and provide adequate provision for people with complex needs, it stresses.

The charter also calls for statutory minimum requirements for labelling, including health warnings, tighter restrictions on marketing – also enforced by statutory regulation – and a government-funded programme of health campaigns 'without industry involvement'. PHE's recent partnership with Drinkaware for the 'Drink Free Days' campaign proved controversial and led to the resignation of Professor Sir Ian Gilmore as co-chair of PHE's alcohol leadership board (*DDN*, October, page 5).

'With dozens of alcohol-related deaths across the UK every day, we decided that rather than wait ages for the government's alcohol strategy we should promote a programme of actions which could reduce harm levels dramatically,' said co-chair of the Drugs, Alcohol & Justice Cross-Party Parliamentary Group, Mary Glindon MP.

'This *Alcohol Charter* is an important document which outlines many policies that the AHA has been calling for,' added Gilmore in his capacity as Alcohol Health Alliance (AHA) chair. 'The government needs to ensure that the upcoming alcohol strategy includes evidence-based policies which work to reduce alcohol harm and tackle the increased availability of super cheap alcohol. The best ways to do that are by introducing minimum unit pricing in England – which we already have in Scotland and will soon have in Wales – and increasing alcohol duty.'

Document at blenheimcdp.org.uk/news/alcohol-charter

'Rather than wait ages for the government's alcohol strategy we should promote a programme of actions.'

MARY GLINDON MP

DUTERTE 2?

HUMAN RIGHTS ORGANISATIONS have expressed grave concerns about the victory of right-wing candidate Jair Bolsonaro in the Brazilian presidential election. Bolsonaro had campaigned with an 'openly anti-human-rights agenda', said Amnesty International. The new president has promised to grant prior authorisation for law enforcement officials to kill, and told *Time* magazine that president Duterte of the Philippines 'did the right thing for his country'.

Bolsonaro: Duterte 'did the right thing'

UN-SUCCESSFUL

THE UN'S TEN-YEAR STRATEGY to eradicate the international illegal drugs market has been a 'spectacular failure of policy', says an IDPC report. More than 30 jurisdictions still have the death penalty for drugs offences on their statute books, with almost 4,000 people executed over the last decade, the document states. President Duterte's crackdown on drug users in the Philippines has seen around 27,000 extrajudicial killings, while restricted access to controlled medicines has left 75 per cent of the world's population without proper access to pain relief. UNODC strategy is based on a 'discredited "war on drugs" approach that continues to generate a catastrophic impact on health, human rights, security and development, while not even remotely reducing the global supply of illegal drugs', it says.

Taking stock: a decade of drug policy at idpc.net

SPECIALIST PRESCRIPTIONS

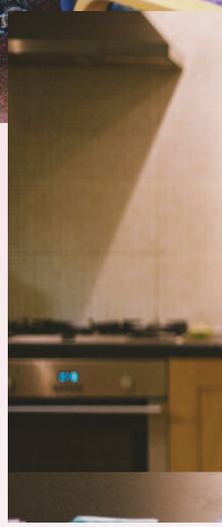
DOCTORS are now able to legally issue prescriptions for cannabis-based medicines for the government has announced. This summer saw a review of the products following high-profile stories about the concerned parents of children with severe epilepsy (*DDN*, July/August, page 5). The decision to prescribe the products, however, will need to be made by a specialist doctor rather than a GP.

DIFFERENT CLASS

THE PRESCRIPTION DRUGS gabapentin and pregabalin are to be reclassified as class C substances from next April, the government has announced. Gabapentin was developed as an anticonvulsant for epilepsy but is mostly prescribed for nerve pain such as sciatica, while pregabalin is used to treat both nerve pain and anxiety. The ACMD, however, has previously raised concerns about misuse and illegal diversion. While the drugs will still be available on prescription there will be stronger controls to 'ensure accountability' and minimise the chance of them 'falling into the wrong hands or being stockpiled by patients', the government says.

COUNTY CRACKDOWN

MORE THAN 200 PEOPLE were arrested as part of a week long period of 'intensive law enforcement activity' to tackle county lines drugs gangs, the National Crime Agency (NCA) has announced. Nearly 60 vulnerable people, including children, were also identified and safeguarded. 'Every territorial police force in England and Wales has now reported some level of county lines activity,' said NCA national county lines lead Sue Southern.



A sensitive approach can be a lifeline to women whose lives revolve around drugs and sex work, as **DDN** reports

The POWER of co

'Without these guys I probably would be dead now.' These are the words of a woman who accessed the SWOP drop-in at a stage in her life when she thought nothing would ever change.

The Sex Worker Outreach Project (SWOP) was set up by the Nelson Trust specifically to help women who had become involved in street-based sex work to fund their addiction. The specialist programme grew from a knowledge base of working with some of the most disadvantaged, marginalised and stigmatised women in the community, and the realisation that intervention could be extremely successful in changing the lives of people who would not otherwise come into contact with services.

'It can take a long time to gain a woman's trust,' says SWOP co-ordinator Katie Lewis. 'Sometimes they have been through services many times before and their needs may not have been addressed appropriately.' These needs can be extremely complex. Many of the women SWOP comes into contact with have experienced abuse, trauma and sexual exploitation before adulthood. For some, engaging in 'transactional sex' has become a practical way of affording accommodation and drugs. Many have families – and many have come to accept that living with a controlling and abusive partner is the norm.

Unsurprisingly, women in this situation are highly unlikely to walk through the door of a daytime service – not just because the hours don't suit them, but also because of the stigma they have experienced. So SWOP goes out onto the streets to try to engage women who are likely to be at risk, offering hot food and drinks, clothes, toiletries and the all-important emotional support.

'We work extremely hard to engage women from a non-judgemental and trauma-informed approach,' says Lewis. 'We offer kindness and give women the safe space to be listened to.' Offering support also involves encouraging the women to engage with other specialist support services, she explains, 'and if it takes ten to 12 attempts for a woman to engage, we will continue to offer this support until she is ready to accept the help.'

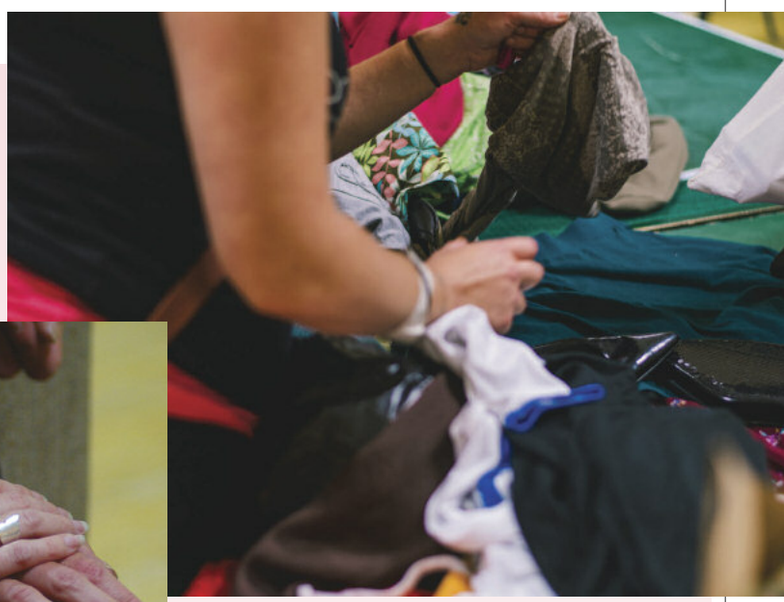
Developing local partnerships has been central to the project's effectiveness and SWOP works with police and probation, social care, child protection, housing and substance use treatment services, among many others. As SWOP co-ordinator, Lewis supports case workers to navigate complex conditions and chairs a monthly multi-agency forum, where all the partner agencies come together to discuss safeguarding and risks for the women, sharing information on how best to support them.

It's a sensitive process that needs to be mindful of clients' confidentiality, but Lewis is careful to protect the 'trusting and respectful relationships' they have built up. 'If they were to disclose any safeguarding or risk information, we would have an honest conversation about when information needs to be shared,' she says.

While it can take many attempts to engage with the women, through out-of-hours services, there is much to offer them in the safe spaces of the van in Swindon and Wiltshire or the drop-in centre at Gloucester. Both environments offer a place of respite and safety, and over food and hot drinks they have the opportunity to talk about the support they need. Some need protection from clients and stalkers; others need help with abusive relationships at home. Many need help with finding safer accommodation for themselves and their children, and there is often

'If it takes ten to 12 attempts for a woman to engage, we will continue to offer this support until she is ready.'

More on outreach work at www.drinkanddrugsnews.com



Images: www.nelsontrust.com

nnection

the need for help at different stages of the criminal justice system – from attending court to 'through the gate' support when leaving prison.

At each stage SWOP encourages feedback, which helps the team adapt and grow their services. 'We're always consulting our women on how they want their services, and this may mean changing times of delivering outreach or providing more underwear,' says Lewis. 'We listen to our women and give them a voice.'

Improving the women's health is a driving force of SWOP's work and the approach is grounded in harm reduction. The network of partner agencies enables swift referral to treat sexually transmitted diseases, infections and HIV, and working with sexual health and homeless health teams helps with access to testing and healthcare. There are often mental health issues to address, particularly where distress has led to suicidal thoughts.

Tackling clients' addiction can be a gradual step-by-step process that needs support from different partner projects and agencies. SWOP has developed three specialist interventions for sex workers, each of them based on giving women a safe space to explore their feelings about sex work while providing emotional and practical support.

At the harm minimisation end of the scale, the Pegasus Programme works through assertive outreach or prison inreach, night drop-ins and intensive key work with women who are actively sex working. The Griffin Programme offers drug and alcohol treatment at an abstinence-based residential treatment centre to women who are no longer actively sex working; while the Phoenix Programme gives aftercare to women who have been in recovery for over three years, but who still need support. All three programmes use shared experience and the concept of connectedness to reframe past trauma and explore the concept of choice for the future.

The work is challenging in many different ways, particularly when it can take many attempts to make the first successful connection, but Lewis says it's the women they help that keep the team motivated. 'We work with some of the strongest women I have met, who face adversity and prejudice daily,' she says. 'They empower us to continue to support them to exit sex working – and when we see an outcome of supporting one of our women to rehab, we know our model works.' **DDN**

Partnership of trust: Rachel's story

RACHEL (NOT HER REAL NAME) was street sex working most nights to fund her addiction when she was encouraged to engage with SWOP by other women who had accessed the service. She was very anxious about getting involved, but she was experiencing housing problems and had been a victim of domestic abuse.

Because of her anxiety and feeling 'very closed up' she would sporadically engage by accessing evening drop-in services only. She mentioned she wanted to exit sex working and quit drugs, so SWOP offered her support and encouragement to leave sex work and access treatment for her addiction.

After building a trusting and safe relationship with her key worker, Rachel was supported to access a script through the drug and alcohol service and reduced the frequency of her drug use and sex working. She was also now accessing the Nelson Trust Women's Centre in the daytime, where she attended the Pegasus intervention.

Following regular intensive key worker sessions, Rachel hadn't taken drugs for three months and hadn't sex worked in more than four months. This enabled her to focus on her housing situation and pay off all her rent arrears by accessing benefits and learning to budget. SWOP supported her to access safe housing through a local housing provider.

After a year of Rachel's engagement with her key worker and partner agencies, she was able to exit sex work and is now in recovery. She has resettled into recovery accommodation for women only and finds she is 'at peace' there. She has found the courage to reconnect with her mum – something she longed for.

There have been many ups and downs but her relationship with her key worker helped her keep her strength and determination. Rachel's hope for her future is that she will be able to peer mentor women who want to exit sex work.

BUPRENORPHINE

TREATMENT CRISIS

Action is needed now to stop the spiralling costs of buprenorphine, says **Roz Gittins**

We want to offer high quality, safe, cost-effective services to as many people as we can – that's why we all go to work in the morning. That's our passion and our goal. Over the past few months, the spiralling costs of buprenorphine are threatening the vital work of all of us in this sector and more importantly the treatment plans of thousands of clients.

Currently, clients are given the choice to decide whether to use medications, mostly methadone or buprenorphine, as part of their treatment for opioid dependency. They make their own decision about their future, based on their own personal needs. They are empowered to steer their own recovery.

And let's not forget, there can be a considerable difference in the effects and patient experience between the two medications. Buprenorphine may be associated with a reduced risk of overdose compared to methadone because it partially blocks other opioids. So if an individual takes heroin on top, they won't experience the usual effects associated with it, and are usually put off doing so.

Buprenorphine can also make people more clear-headed than methadone so may be preferred by some people who are working. Often parents also prefer it because the risks from unintended ingestion are far lower because buprenorphine tablets don't work if they are swallowed (they should be dissolved under the tongue).

Just six months ago, the cost of buprenorphine was about £15 for a month's supply. Now it's closer to £130. In one of our services, the prescribing bill for buprenorphine shot up from nearly £3,000 to over £21,000 in just two months.

While we're continuing to support clients prescribed buprenorphine, the long-term sustainability of this will be put in jeopardy if prices remain this high. In normal practice the option of switching from buprenorphine over to methadone would only be considered if clinically appropriate and if the client makes an informed choice to make the change.

Transferring someone for cost or supply reasons could generate significant anxiety and have a serious impact on the trust between the client and the provider, which in turn could damage their future engagement.

Changing to methadone may also destabilise clients or make them feel that they have been 'put' on treatment where they have previously 'failed'. At a time when drug-related deaths are higher than ever before do we really want service providers and commissioners to be forced into that position?

The importance of a client's confidence in their treatment cannot be underestimated. Yet because the cost of this medication increased by more than 700 per cent for some of our services, we have worried clients and frustrated staff, who while knowing the life-saving benefits of buprenorphine are being forced to think about the costs.

It's estimated there are around 30,000 people in England using buprenorphine as part of their recovery plans. That's 30,000 parents, brothers, sisters, sons, daughters and friends, who are already doing the best they can with their recovery, experiencing extra anxiety.

It's not in our control. It's not sustainable. It's not OK.

At Addaction, we're calling for the government to do more. More should be done to monitor the price and supply of this crucial drug within the UK and we want to see adequate contingency mechanisms in place to ensure sudden shortages and price increases do not happen or are quickly dealt with.

Roz Gittins is director of pharmacy at Addaction

'Just six months ago, the cost of buprenorphine was about £15 for a month's supply. Now it's closer to £130. In one of our services, the prescribing bill for buprenorphine shot up from nearly £3,000 to over £21,000 in just two months.'

PAYING THE PRICE

The rising cost of buprenorphine has caused serious concern in the treatment field. **DDN** looks at the issues behind it.

The generic drug market can be a volatile one, with companies ceasing supply or switching production of drugs at little notice and with consequent shortages in supply. While government pricing control mechanisms to manage these shortages rarely affect the treatment field – as it prescribes far fewer drugs than wider health services – in the case of buprenorphine the impact has undoubtedly been felt.

The drugs recommended by NICE and the *Drug misuse and dependence* 'orange book' guidelines as maintenance for people with opioid problems are methadone and buprenorphine. However, as Addaction's article opposite states, while the latter is the preferred option for many clients, a shortage has led to the price of generic buprenorphine sublingual tablets rising sharply in recent months. This has hit parts of the treatment sector – already struggling with shrinking budgets – hard.

Drug pricing mechanisms can seem complicated and opaque. The UK pharmaceutical sector is strictly regulated, with prices agreed via the Department of Health and Social Care (DHSC). NCSO (No Cheaper Stock Obtainable) is a special concessionary pricing status negotiated by the Pharmaceutical Services Negotiating Committee (PSNC), enabling a set number of drugs above the drug tariff price to be reimbursed at a higher level than that price. The tariff is produced every month by NHS Prescription Services on behalf of DHSC, and then supplied to pharmacists and other bodies.

In May, Public Health England (PHE) wrote to directors of public health in response to concerns from some pharmacists and treatment providers about the availability of generic 2mg buprenorphine tablets. The letter explained that while branded buprenorphine is more expensive than the generic product used by many services, pharmacists are paid a standard price as set out in the tariff for 'whichever product they dispense against a prescription for generic buprenorphine', adding that the reimbursement price can change according to market conditions. While the NHS is used to managing these fluctuations and temporary concessionary prices, as PHE's letter pointed out the limited range of medicines used in drug treatment means less scope to do that.

A further briefing in September stated that the agency recognised the 'severe financial problems'; that continuing supply issues and raised prices were causing, and in late October PHE once again wrote to directors of public health explaining that the concessionary price had remained higher than the reimbursement price, and stressing that PHE had continued to work closely with DHSC and treatment providers to 'understand the issues and their impact, and what can be done to mitigate any resulting problems'.

This most recent letter states that while the original supply issue has been resolved, supplies of generic buprenorphine remain limited and pharmacists have continued to rely on more expensive branded products, meaning that treatment services and commissioners will 'see increased drugs bills for most, if not all, of 2018 and potentially beyond that'.

The letter ends with a statement that local authorities may need to 'reflect on the medicines element in their budget for drug treatment'. Given this, what is a realistic timescale until the situation might be resolved? 'The bottom line is that no one knows,' Pete Burkinshaw, alcohol and drug treatment and recovery lead at PHE, tells *DDN*.

'The price is determined by the market conditions, and they can change rapidly. Essentially the old tariff price was the market price for buprenorphine in this country and it was low for a long time, particularly in comparison to other countries in Europe. Perhaps it was unsustainably low and the recent changes may be to some extent a natural correction, or competition may increase again and the price would then fall.'

What PHE was communicating in its recent letter to local authorities was that their planning needs to be done 'in the context that the recent changes may well be long term and not a temporary blip', he adds. 'The medicines market is fluid and all we can say with any confidence is the market conditions have changed, and that no one can predict them with any absolute certainty.'

On calls for the government to put contingencies in place he states that PHE is 'raising questions within government persistently, and making the relevant people aware of the unique set of circumstances and the impact on drug treatment. However, it is very difficult and unprecedented for government to intervene in markets. This is a very complex issue and no centralised solution or mitigation is likely or perhaps even possible in the immediate future. We have explored many options with colleagues but none have been possible.'

Fluctuations in the medicines market are common and appear to be 'particularly frequent at the moment', he states. 'The NHS and DHSC regularly have to deal with these issues but on a far larger scale than the current buprenorphine issue. However, we have gone to great lengths to point out that this is being felt particularly acutely by the drug and alcohol treatment sector and that there are – and will be increasingly – direct and immediate consequences. This is largely because of the very small number of medicines used by the sector which are funded from discrete budgets, which means that any peak cannot be absorbed by reductions in the price of other medicines.

'This is further compounded by the financial pressures local authorities and services are currently under. We are confident that message is now understood, and we will continue to do everything we possibly can.' **DDN**

THE FIX RIGHT?

Safe injecting sites, drug consumption rooms, safe injecting facilities, fix rooms or the rather more grandiose medically supervised injecting centres are just some of the many labels applied to legally sanctioned medically supervised drug consumption sites – places where drug users can inject their drugs safely.

The laudable purpose of these sites is to reduce BBVs and overdose, while also reducing the nuisance caused by drug users injecting in public. They also offer users a route into a variety of mainstream services they otherwise might not have come in contact with.

Sounds super great, right? So, why do I always feel so uneasy when the subject comes up? I have to say, part of the unease comes from the reaction to anyone questioning the virtue of safe injecting sites – a reaction which ranges from scorn to outright hostility. Consequently an orthodoxy is being created around the subject, and in my experience unquestioned orthodoxies tend to lead to poor policy – and there's more than enough of that out there already!

My unease, however, goes beyond a personal dislike of the virtue signalling and group-think that cloud the issue. There are several concrete reasons for concern regarding the costs that come with the safe injecting sites – costs that really need addressing and analysing.

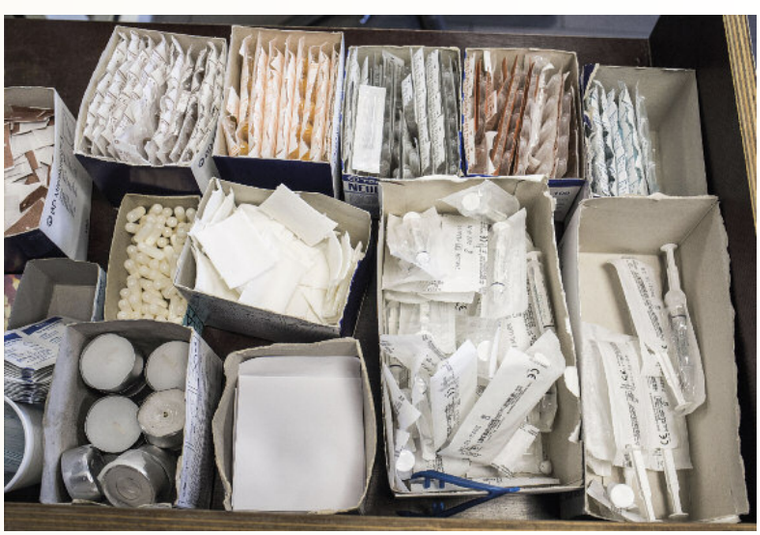
Firstly, there will inevitably be a cost in community relations. Nothing exists in a vacuum – especially not property prices which, given the amount of stigma around IV drug use, will inevitably drop at the first mention of a safe injecting site in the neighbourhood. While it's tempting to mock this sort of ignorance-based nimbyism, it would be wiser to realise that anything that further erodes the troubled relationship between drug users and wider society should be treated carefully.

Then there's the inevitable political cost. By this I mean that admitting an area needs a safe injecting site is equivalent to admitting that a laundry list of policies – including housing, mental health, welfare and addiction polices – have all failed miserably, and politicians don't like admitting and taking ownership of that kind of collection of failures. Persuading them otherwise takes a concerted effort – effort that could have been used to persuade them to adopt other, less glamorous, but more productive policies. Far too often substance misuse is an afterthought for politicians. Can the bandwidth they do devote to the subject be better used?

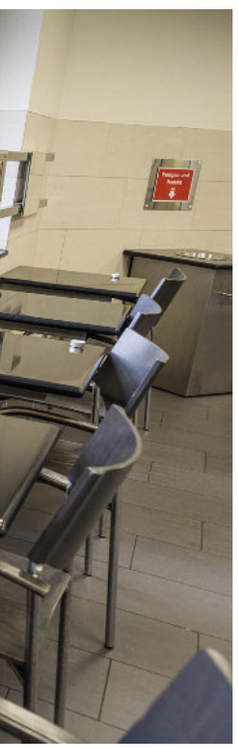
Then there's the bottom-line cost. Money is an ugly subject, but sadly it's always relevant – especially in an age of austerity and government indifference.

Before we go any further I keep hearing comments like 'safe injecting sites can be cheap – you just need a tent and some works'. Guys, that's not a safe injecting site. That's a shooting gallery in a tent! Unfortunately the things that differentiate between a shooting gallery and a safe injecting site tend to be expensive and range from the cost of premises to the most important of all – the cost of suitable staff. Done right, a safe injecting site is not a cheap option.

Importantly, it also needs pointing out that while offering a valuable service to the drug users who use them, the majority of drug users won't use a safe injecting site. Not even a majority of IV drug users will use them – including me. I won't use a safe injecting site because I'm fortunate enough to have a home. Even if I were homeless I wouldn't travel far, pay for public transport, or spend



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



Consumption rooms in Germany. The centres provide clean drug paraphernalia as well as advice on how to use safely. There are also on-site counselling programmes, which aim to refer users to treatment programmes. They also provide free condoms and affordable meals and often have showers and laundry services.

time travelling to use a safe injecting site, and I'm far from alone in this. In fact while preparing to write this article I asked several current and past IV drug users what they thought of safe injecting sites. To a man/woman they replied they were a wonderful idea, but when asked if they'd use them personally they universally replied 'NO'.

Safe injecting sites' clientele will tend to be chaotic, homeless users with complex problems, and that's a small subset of not just drug users, but also a small subset of IV drug users – a very vulnerable, very visible subset, yet still a subset. So, the question is, is it acceptable to furnish the significant cost of a site that will only be used by a small percentage of drug users from a budget aimed at a much wider community of drug users?

I must admit that one of my pet peeves is that drug treatment is rarely designed for the primary purpose of helping drug users. Instead it tends to be designed to protect wider society from drug users by reducing crime, reducing the spread of BBVs in society and even by attempting to make drug users more economically productive. Safe injecting sites fit firmly into this peeve because it's easy to see the benefit for local merchants and residents, but it's a lot harder to discern much of a benefit to the majority of IV drug users.

> '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...'

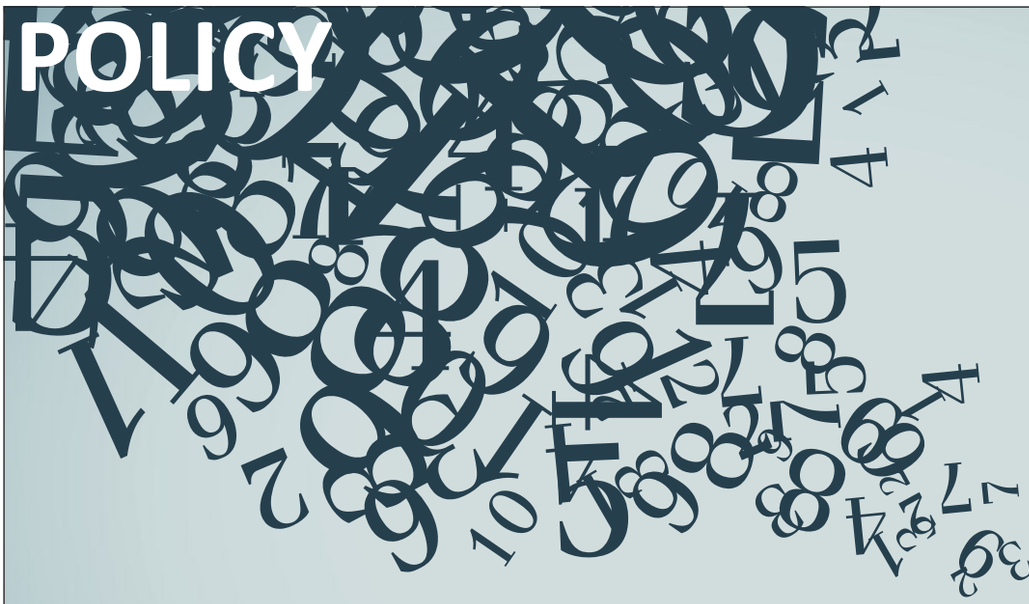
At my most cynical I feel there's something disturbing about an approach that can easily be seen as saying 'come in for half an hour, have a shot so you don't scare the public and then fuck off back to your cardboard box'. I'm sorry, but there are far more effective ways of helping a larger percentage of IV users – like the far more prosaic re-evaluation and design of housing, welfare, mental health and drug treatment services in the area for a start.

In October 2018 a safe injecting site shouldn't be a priority in England. However, in other parts of the world they're a viable policy option. In America the opioid epidemic and open air drug markets (which cause users to congregate in one place) make safe injecting sites viable. In Europe and Australia they're the fruit of better funding and treatment philosophy, but in England the situation is different. This is not to say things won't change – it would take a brave person to bet that the gradual arrival of fentanyl and other research chemical opioids won't completely change the equation and push safe injecting sites up the agenda, but in the here and now we have other more pressing needs.

If, or rather when, the situation in England changes, then safe injecting sites may well become a viable treatment option, and when that time comes there's much that can be done to mitigate the costs involved. We can accept that the sites should be temporary and serve as an emergency measure while the fundamental issues underlying their need are fixed. Temporary sites would also do much to allay local community concerns regarding their impact. A temporary safe injecting site also opens the door to using pre-fabricated buildings or converted buses, which would help to reduce the financial cost. So, there are options that can be taken to help make safe injecting sites viable in the future – IF they become needed.

As it is today, safe injecting sites aren't an exciting panacea to all drug users' problems. They are in fact a luxury in an age of austerity and all the virtue signalling and group-think in the world won't change that.

Nick Goldstein is a service user



Statistics on drug-related deaths should be informing our strategy. **DDN** reports from the Drugs, Alcohol and Criminal Justice Cross-Party Parliamentary Group

MORE THAN NUMBERS

LATEST STATISTICS relating to drug poisoning, released by the Office for National Statistics (ONS), show no significant change in the number of deaths in England and Wales between 2016-17. There were 3,756 deaths in 2017 (DDN, September, page 4), with two-thirds of drug-related deaths relating to drug misuse. The most common cause of death was accidental poisoning.

Speaking at the Drugs, Alcohol and Criminal Justice Cross-Party Parliamentary Group, Sarah Caul, ONS senior research officer, gave more detailed insight. Deaths involving cocaine and fentanyl had continued to rise – by 29 per cent in the case of fentanyl – while deaths relating to new psychoactive substances (NPS) had halved.

There was now a more detailed breakdown of mortality rates available by country and region, with the North East of England showing significantly higher rates than all other English regions, and London recording a significantly lower rate. The annual statistics could be affected by different timescales for recording the deaths in different regions, she added.

'When you show a map of areas, it almost entirely maps deprivation,' commented Alex Boyt. 'Then you throw in austerity, homelessness and the reduction of funding for treatment and it gives a much bigger picture.' Sunny Dhadley added that it would be useful to know more about the background of people who had passed away, to 'learn more about the story behind the figures'.

'Our job is to give as much evidence as we can,' responded Caul, citing the ONS article published in April that showed that more than half of heroin/morphine misuse death hotspots in England and Wales were seaside locations. Furthermore, an experimental 'deep dive' into coroners' records relating to drug misuse, published in August, gave observations on the health and lifestyle of the deceased and the extent of their contact with health services. There was far greater scope to expand this exercise and gain much better understanding of the individual pathways of those who had died from drug-related causes. (Both articles available at www.ons.gov.uk)

The second speaker was Rudi Fortson QC, an independent practising barrister known for his work on drug law. 'Five thousand drug-related deaths a year in England, Wales and Scotland is wholly unacceptable,' he said. So what should be our approach, he asked the group. How should we deal with two separate issues of chaotic drug use and recreational drug use?

'We've seen a marked increase in homelessness and rough sleeping, a major cause of drug-related deaths,' he said. 'People who aren't drug users who become homeless, become drug users. So we need to provide a safe environment.' This could be warden-assisted housing, with a warden trained about drug use, or it could take the form of facilities for safer drug-taking.

'I'm very enthusiastic about piloting a medically supervised drug-using facility somewhere in the UK,' said Fortson. 'I know they're very contentious, but I also know they work when well managed.'

Hamburg had this down 'to a fine art' with a combination of 'carrot and stick', while Barcelona modelled its facilities on safe usage and hygiene, with medical supervision, counselling services, clean clothes, a launderette and food.

It had to be 'multi-level' with police a key part of encouraging users to go to the drug consumption room (DCR) he said. Visiting Toronto last year, he had seen two consumption rooms and witnessed how having medical facilities allowed them to respond very quickly.

There were 92 facilities around the world 'and this country is not even piloting one – why not?' he asked. 'It's a disgrace.'

As the group debated the merits of DCRs, Fortson said the evidence showed that they saved lives: 'There have been overdoses but not deaths, as medical professionals are there to support,' he said. He added that DCRs worked best when there were several in the same city, rather than just one.

Mike Trace, chief executive of The Forward Trust cautioned against seeing DCRs as a 'policy panacea'. They were one of several support mechanisms alongside naloxone, and would make a difference. 'But we need to be careful about promoting them as a public health solution,' he said.

Turning to consider recreational drug use, Fortson declared himself a big fan of The Loop, for whom he was informal legal advisor. Providing a free and completely non-judgemental drug testing service as festivals and clubs, their service had highlighted that many drugs were dangerously mis-sold, such as plaster of Paris passed off as MDMA.

'It took me by surprise to see queues at the Boomtown festival of people waiting to have drugs tested,' he said. 'If The Loop hadn't been at this festival, what would the effects of these substances have been? Illness and possibly death. A high proportion of people threw their drugs away on learning the results.' It was important that the service was well managed he said, as The Loop was by Fiona Meesham, but the multi-agency approach including police was proving highly effective.

'We know there are ways that already work to stop drug-related deaths, so let's provide more funding for facilities,' he concluded. **DDN**

Does intranasal naloxone have a role in substance misuse services, asks **Graham Parsons**

NEW OPTIONS ON NALOXONE

THE LAUNCH OF NALOXONE NASAL SPRAY in September 2018 provides substance misuse practitioners with another tool to support harm reduction. Although the premium price of £27.50 per pack plus VAT, 52 per cent more expensive than intramuscular (IM) naloxone, may restrict its supply in a sector already suffering significant cuts – including substantial buprenorphine costs associated with its recent short-supply (see page 8) – there are some advantages associated with the new formulation. This short article will try to consider both the advantages and disadvantages of intranasal (IN) naloxone and where its place in the sector might be.

Naloxone is an emergency antidote drug that reverses an opioid overdose and can save a client's life. Its distribution is supported by the Advisory Council on the Misuse of Drugs (ACMD), Public Health England (PHE), the World Health Organization (WHO) and many other national and international bodies. Under current legislation, parenteral naloxone can be provided to clients and their families, friends or carers by 'any person employed or engaged in the provision of drug treatment services'. This has led to a number of drug treatment providers providing take-home naloxone (THN) to their clients and families, friends or carers since the legislation change in October 2015.

The IN naloxone pack contains two individual nasal sprays each containing 1.8mg of naloxone in 0.1ml solution. Pharmacokinetic studies (studies investigating the drugs availability in the body after it has been given) suggest the nasal spray is equivalent to a 0.4mg dose of IM naloxone. The onset of action is slower but the IN formulation has a longer half-life (1.27hrs vs. 1.09hrs).

The training material provided by the company advises that one dose of IN naloxone should be administered where opioid overdose is suspected, with a second dose given if there is no improvement after two to three minutes or the opioid overdose symptoms come back. The usual harm reduction advice, for example call an ambulance, is also recommended in the training material. The shelf life for the product is similar to licensed IM naloxone product (30 months compared to 36 months) and there are no special temperature storage requirements other than to protect from light and store in the original container.

IN naloxone is licensed for use from the age of 14 as opposed to 18 for the licenced IM naloxone formulation. This provides a useful alternative for the 14 to 17 age group, where the use of the licensed IM naloxone formulation is off-label, *ie* outside the recommendations provided by the company. Pragmatically many services have supplied IM naloxone to under-18s within a defined protocol based on a risk to benefit analysis, but the availability of a licensed product in this age group is a welcome addition.

IN naloxone may also be a useful addition in situations where clients and/or their carers or families have difficulties using the licenced IM formulation. This may be, for example, due to concerns around needle-stick injuries or difficulties in demonstrating a good technique with an IM formulation.

Unfortunately the current legislation supporting the supply of naloxone (2015 SI 1503) only covers the distribution of parenteral (ie injectable) naloxone, not IN naloxone. In effect this means that currently it can only be supplied on a prescription to a named patient or via a patient group direction (PGD) or patient specific direction (PSD). This is an issue which I understand is being addressed but will probably not hit the statute book until 2019. The manufacturers also warn that absorption of the drug may be affected in clients with a damaged nasal mucosa and septal defects.

> 'Current legislation supporting the supply of naloxone only covers the distribution of injectable naloxone. This is clearly an issue which I understand is being addressed...'

Support for services who may want to supply IN naloxone has not been at the same level as that provided when the licensed IM naloxone product was initially launched. No face-to-face training is being offered and placebo (dummy) packs are not being provided to services. Patient Information Leaflets (PILs) are also not being provided in paper copies, with services being asked to print off copies via a dedicated website.

In conclusion there does seem to be a place for IN naloxone in our substance misuse services. However, the cost and current legislative issues around the supply method may limit its role to selective groups.

Graham Parsons is chief pharmacist and pharmacist prescriber at Turning Point

More good practice stories at www.drinkanddrugsnews.com

Just have the chat

Addaction is urging parents to take time out to talk to their teenagers about drugs, as **Karen Tyrell** explains

addaction

IT'S NATURAL TO WANT TO PROTECT YOUR CHILD. But as kids grow into teens they want to take risks – it's part of the way they learn about the world. Telling a teenager to 'just say no' isn't helpful and is often counterproductive. Our advice is start the chat, keep talking, listen well, and don't turn it into a big thing.

Many parents don't feel confident about giving advice about drugs to their teenagers, so our Have the Chat campaign offers seven tips for parents to start the conversation about drugs:

'We know the "just say no" message doesn't work – in fact it can have the opposite effect.'

1. DON'T MAKE IT A BIG THING
Everyone will feel awkward if you treat it like a 'big talk'... including you. Try to think of it as the start of a regular conversation. You want to show your kids it's OK to talk about drugs.

2. PICK THE RIGHT MOMENT
You'll need a time and place when you both feel comfortable. Side-by-side chats can help put everyone at ease – try a car journey or a walk.

3. DON'T FEEL LIKE YOU HAVE TO BE AN EXPERT
No one knows about every drug. But you're the expert on your own kids. Think about your own experience and draw on that. Do some research too if you need to.

4. LISTEN WITHOUT LECTURING
We know the 'just say no' message doesn't work – in fact it can have the opposite effect. Your teenager won't want to talk if they feel judged or preached at.

5. BE PATIENT
Kids will need a bit of time and space to think about what you discuss. This is normal and not something to worry about. But make sure they know they can come to you if things go wrong. No conversation is out of bounds; you're always there to help.

6. BE REALISTIC
There's a good chance your teenager will come into contact with cigarettes, drugs or alcohol at some point. It's important to be realistic, even if that feels scary. If you start the conversation, be prepared to hear answers you might not like.

7. DON'T GIVE UP
Be kind to yourself and remember that this isn't a pass/fail test. These things take time – even if the conversation doesn't go the way you want, an initial chat can help sow a seed for the future.

Parents who want support can use Addaction's free and confidential web chat service, staffed by trained advisors. A range of resources is at www.addaction.org.uk

Karen Tyrell is executive director of external affairs at Addaction

A PAUSE FROM CHAOS

Trevi House is launching a new programme to help vulnerable women break the cycle of having their children removed, says **Hannah Shead**

BETWEEN 2007 AND 2014, 11,000 mothers had more than one child removed, placing a huge strain on the care system. Through our new contract to deliver the Pause programme in partnership with Plymouth City Council, Trevi House will be able to support women to break the devastating cycle of having multiple children removed through care proceedings.

Pause Plymouth will give up to 48 women the opportunity to take a 'pause' from the periods of chaos and anger that typically follow care proceedings, creating instead a space for them to reflect, learn and aspire. When the doors open in April 2019, women will receive intensive bespoke support that has not previously been available to them, helping them to avoid or break this cycle.

This is vital work. Across the UK, care applications are at their highest level since 2012, with a total of 72,670 children in care. Two-thirds of cases involve parental substance misuse, while 25 per cent of women who have had a child removed go onto have another child, often leading to repeated removals.

For the past 25 years Trevi House has worked with hundreds of women and their children – at a residential rehab and more recently through outreach at our Sunflower Women's Centre – getting mum off drugs or alcohol for good and giving her the skills to be the best parent she possibly can.

Many of the women that are admitted to Trevi House have previously had numerous children removed, and we know the subsequent trauma caused if they become pregnant again before having the opportunity to recover.

Pause complements our existing work and provides the much-needed support for cases where reunification is not achievable. It would be easy to write these women off – but given the right support, nurture and specialist interventions, change is absolutely possible.

Hannah Shead is CEO of Trevi House

'In April 2019, women will receive intensive bespoke support that has not previously been available to them...'

Launching the Alcohol Charter, key figures from the sector called for a definitive alcohol strategy based on evidence, as **DDN** reports

CLEAR STEER ON ALCOHOL

THE GOVERNMENT SHOULD TAKE IMMEDIATE ACTION to reduce alcohol-related harm through an evidence-based strategy, according to a new alcohol charter (see news, page 5).

Launching the charter at a well-attended meeting in Westminster, Sir Ian Gilmore said we must lead internationally on alcohol strategy. The 'penny hadn't dropped' as far as alcohol was concerned, he believed, with government pursuing a strategy that wasn't evidence based, around licensing, marketing and treatment.

'Treatment is the part we should be most ashamed of,' he said. We needed to look at comorbidities, the rise in mental health issues, and at social responsibility – the 'innocent bystanders' affected by alcohol problems. Without tangible counter measures, alcohol-related health issues were set to cost the NHS £17bn in the next five years.

The charter gave a 'clear footprint for government to follow' and would address the 'huge toll on crime and health', said Gilmore. 'I am delighted that the charter commits to giving the public information and evidence-based guidelines on units,' he added. 'Until we get government-funded campaigns the public will stay in the dark. There's more information on a bottle of milk than a bottle of wine.'

Next to speak, Dr James Nicholls of Alcohol Research UK and Alcohol Concern said that treatment services were being 'hammered', with two-thirds of local authorities having cut treatment budgets – a situation that was 'absolutely unsustainable'.

'These swingeing cuts are hitting the most deprived communities,' he said. One of the main risks of budget cuts was the effect on assertive outreach: there had been a 19 per cent fall in presentations for alcohol-only treatment, but not the same fall in the levels of need. Working with these people cost more but gave the greatest savings to the NHS.

'People turn up at A&E again and again. There's a human cost and an economic cost,' he said. The charter proposed a 1 per cent 'treatment levy' through increasing alcohol duties – a move that would provide £100m extra investment and pay for 24-hour teams in hospitals.

Jennifer Keen from the Institute of Alcohol Studies said that with drinking rates doubling since the 1950s and 1m hospital admission a year, it was 'imperative' that we addressed these issues. One theme ran through the charter – the affordability of alcohol, which drove consumption and harm. But she emphasised that resolving the issue was about more than increasing duty. The tax system wasn't fit for purpose, with beer and spirits taxed differently to wine and cider and incentive for manufacturers to make their products stronger.

'The government has said they won't include minimum unit pricing in their strategy, but we hope this charter will encourage them to think again,' she said.

Fiona Bruce, chair of the APPG on Alcohol Harm admitted there was 'no single silver bullet' and 'a variety of solutions to tackle this epidemic'. It was encouraging to see that young people were drinking less, but a lot more needed to be done, particularly for the older generations.

'There is something for everyone in this charter,' she said. 'Working together, we are beginning to strike up a national conversation so many of us want to have.' **DDN**

Charter available at www.blenheimcdp.org.uk/news/alcohol-charter

CALL TO ACTION

'Alcohol harm is avoidable. This charter provides the government with practical, workable measures to include in the upcoming alcohol strategy, including the treatment levy, that will reduce alcohol harm and improve people's lives across the country.'
Richard Piper, Alcohol Research UK

'The government needs to ensure that the upcoming alcohol strategy includes evidence-based policies which work to reduce alcohol harm and tackle the increased availability of super-cheap alcohol. The best way to do that is by introducing minimum unit pricing in England – which we already have in Scotland and will soon have in Wales – and increasing alcohol duty.'
Sir Ian Gilmore, Alcohol Health Alliance

'This charter brings together voices from the entire alcohol policy field: the medical community, treatment providers, social care professionals, leading researchers, criminal justice advocates, and experts by experience... It sets out a clear course of action for the government and I urge them to include these policies in the alcohol strategy.'
Jennifer Keen, Institute for Alcohol Studies

'We need to invest money in specialist services for people with an alcohol dependency. At the moment only one in five people who desperately need treatment can get it. That's not good enough. It heaps pressure on our health services, but most importantly, it means we're only reaching a fraction of those who need our help.'
Karen Tyrell, Addaction

'The charter provides clear direction for the government in dealing with this important and problematic issue. As everyone knows, the cost to the individual and society as a whole is significant. This is a call to action!'
Yasmin Batliwala, WDP

'There will be 1.2m alcohol-linked cancer cases in the next ten years and alcohol is set to cost the NHS £17bn in the next five years. We urgently need a new alcohol strategy to lead the way internationally in reducing the damage to society. This charter sets out how it can be done with a realistic evidenced based, yet pioneering set of demands that we urge government to adopt.'
John Jolly, Blenheim

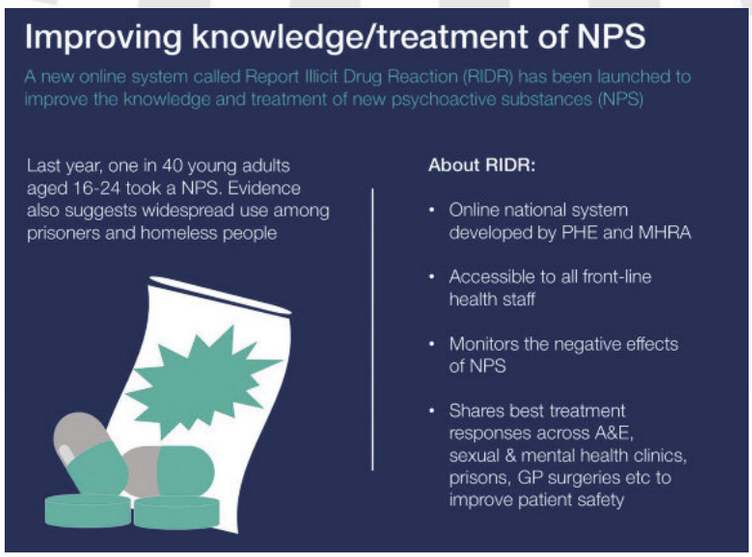
On the right tra

We can all contribute to understanding new drug health harms and developing treatment responses more quickly, says **Laura Pechey**

Did you know that you can get the latest intelligence on new psychoactive substances (NPS) and other drug health harms, and guidance to support you in responding to them, in one handy document? Or that you can quickly report to PHE any unusual adverse reactions to NPS and other drugs that you encounter in your service using a simple online form? I'd like to tell you why we've developed a system that does just this and how it can support your work.

Over the last 15 years, a host of new drugs have entered the UK market that were completely unknown before, such as mephedrone or the many different synthetic cannabinoid receptor agonists (SCRAs), sometimes called 'Spice' or 'Mamba'. We have also seen an increase in the misuse of drugs previously only used as medicines. New substances and new patterns of use can bring new health risks that aren't known to users or clinicians. Recent examples of this include retinal damage caused by new compositions of poppers – 'poppers maculopathy', and bladder complaints in heavy ketamine users – 'ketamine bladder'.

Stories of bladder damage caused by ketamine began to emerge on online forums in 2007, when ketamine users were increasingly presenting to A&E with bladder complaints. Regular ketamine users were needing to urinate more often and more urgently, experiencing pelvic, bladder and urethral pain, and seeing blood in their urine. However, many health professionals were initially unaware that these urological problems were associated with ketamine use or how best to treat them.



Working with the MHRA, PHE launched the Reporting Illicit Drug Reactions (RIDR) system in March 2017. The system is intended to be used by health professionals who work in emergency departments, general practice, alcohol and drug treatment, sexual health, mental health and other settings where staff come into contact with people presenting with acute or chronic problems with NPS and other drugs.

While stopping ketamine use can reverse damage in most instances, delays in identifying the cause of the condition were leading some people to experience irreversible damage and, in extreme cases, to undergo radical surgery to remove their bladders. As clinicians began to share information via their networks and through published case reports, the pattern of harm and the need for swift joint work between drug services and urological departments became clear.

CASE STUDY: THE RIGHT DIAGNOSIS

In his own clinical practice, Dr Bowden-Jones recently encountered a case of ketamine bladder at his Club Drug Clinic in London. Katie,* a 30-year old woman, was working as a PA in a large company when she presented to the clinic. During her early twenties, she typically used ketamine and MDMA monthly and cocaine three to four times a year, and binged on alcohol once a week.

Ketamine was Katie's main drug of choice as she liked the feelings of relaxation and disconnection it gave her. While her other drug use fizzled out when she started working, Katie continued to use ketamine. A new relationship with another ketamine user led to Katie using more ketamine, more often, and increasingly at work. The batches that the couple were purchasing online often looked very different from each other and had differing effects; some batches were stimulating, while others had more sedative effects.

Katie came into treatment after using a batch she described as being greenish and crystalline. Katie and her partner experienced nausea, dizziness, vomiting and visual distortions within minutes of using and these symptoms lasted for six hours. In treatment, Katie was diagnosed with an underlying anxiety disorder and 'ketamine bladder.' She had previously seen a GP about painful, frequent urination but had been mistakenly diagnosed with a urinary tract infection (UTI) and prescribed a course of antibiotics.

Dr Bowden-Jones and his team were able to support Katie to understand the extent to which ketamine was causing her physical symptoms and the risks of continuing to use. For ketamine bladder sufferers like Katie, an end to the pain and discomfort that they are experiencing, and avoiding any irreversible damage, can be powerful reasons to reduce or stop their ketamine use.

**Names have been changed.*

'Ketamine was Katie's main drug of choice as she liked the feelings of relaxation and disconnection...'

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NEW NATIONAL REPORTING SYSTEM: RIDR

Cases like ketamine bladder started conversations about how services might work together to speed up our response to emerging drug-related harms. Policymakers, practitioners and other stakeholders thought that one way to do this would be through a centralised national reporting system modelled on the Medicines and Healthcare products Regulatory Agency's (MHRA) yellow card scheme, which has been tracking adverse reactions to pharmaceutical drugs for over 50 years. The thinking was that if frontline health professionals could report the adverse drug reactions that they were seeing on the ground, Public Health England (PHE) would be able to build a more consistent and up-to-date picture of new drug-related health harms as they emerged and reduce the time taken to develop effective treatment responses.

Working with the MHRA, PHE launched the Reporting Illicit Drug Reactions (RIDR) system in March 2017. The system is intended to be used by health professionals who work in emergency departments, general practice, alcohol and drug treatment, sexual health, mental health and other settings where staff come into contact with people presenting with acute or chronic problems with NPS and other drugs. Professionals can submit reports by registering with the RIDR website and giving information about the adverse reactions they have seen, including the individual's symptoms, suspect substance(s), frequency of use, dose and date of presentation.

Since the project launched, 347 reports have been received from a wide range of settings, including prisons, A&E and drug services. More than 60 per cent of the reports to date have been about SCRAs. The most commonly reported adverse reactions are depressed levels of consciousness, slurred speech and drowsiness indicating nervous systems disorders; other common adverse reactions include agitation and acute psychosis.

As well as making reports to RIDR, health professionals can also access the RIDR 'dashboard.' The dashboard gives a brief, up-to-date summary of the latest reported adverse drug effects drawn from RIDR reports and other sources. The RIDR project is supported by a national multi-disciplinary clinical network and is led by Dr Owen Bowden-Jones, consultant psychiatrist and clinical adviser to PHE's Alcohol, Drugs, Tobacco and Justice Division.

Dr Bowden-Jones recognises that 'working with people using NPS and emerging drug combinations is a challenge for all of us on the frontline. Often the dealer doesn't know what they are selling and so the user doesn't know what they have taken, so the clinician will have no idea of the potential harms. This situation requires careful clinical assessment to work out the best way to help.' It is our hope at PHE that RIDR will prove a powerful tool in our hands as health professionals, offering a way of receiving and sharing valuable intelligence from the ground up.

To support you in understanding new and emerging drug-related health harms, we've developed a four point checklist:

- *Get a headline summary of the latest guidance and intelligence on NPS and other drug health harms: report-illicit-drug-reaction.phe.gov.uk/latest-information/*
- *Report the adverse illicit drug reactions that you encounter: report-illicit-drug-reaction.phe.gov.uk/*
- *Get comprehensive guidance on managing the acute and chronic harms of club drugs and NPS: neptune-clinical-guidance.co.uk/clinical-guidance-2/*
- *Complete free, easy-to-use and accessible e-learning on club drugs and NPS: neptune-clinical-guidance.co.uk/e-learning/*

Laura Pechey is a programme manager in the Alcohol, Drugs, Tobacco and Justice Division of Public Health England (PHE)

EXPERIENCE COUNTS

If you're interested in helping the world have honest conversations about drug use, please read on, say **Prof Adam Winstock**, **Dr Monica Barratt**, **Dr Larissa Maier** and **Prof Jason Ferris**

GLOBAL DRUG SURVEY (GDS) is comprised of a network of international experts in the field of drugs, health, epidemiology and public policy. GDS uses an encrypted, online survey platform to conduct annual anonymous surveys, and over the last six years more than 550,000 people have taken part.

Now in its eighth year, our latest survey GDS2019, launching this month, will be translated into 23 languages, with partners in more than 35 countries. Because we are independent, we can focus our attention on achieving our mission of making drug use safer regardless of the legal status of the drug. All our research is approved by university ethics committees and to date has led to 50 peer-reviewed publications in the last six years.

Addressing issues such as overdose prevention, blood-borne viruses, irrational drug policies, inequitable application and human rights violations is central to shifting the way we can reduce harm from drug use on a global scale. GDS complements work done by research and advocacy groups who work for change in these important areas, by focusing on the drug use patterns and potential harms of the hidden masses of non-dependent drug users. In addition, we aim to identify new drug trends before they enter the wider population.

Creating a voice that is trusted for sharing that information is a challenge, especially given that the most trusted source of information on drugs is from others who use drugs. GDS sees its role as translating the expertise and experience of hundreds of thousands of people who use drugs into engaging, credible and useful information about drug use behaviour and free harm reduction resources that are shared by our global media network and via our website.

Taking part in the Global Drug Survey is as important this year as any other year. The world of drugs has changed dramatically in the last decade and we are exploring this brave new world. We'll be looking at some fascinating areas from LSD micro-dosing and the acceptability of psychedelics in psychiatry to how you'd rate different drugs, including alcohol, in terms of value for money. We'll be looking at the impact of health warnings, revisiting drugs and policing, and researching the complex issue of sexual assault and consent in the context of drug and alcohol use. We'll continue our assessment of dark-net drug markets and novel psychoactive drugs and ask the question 'just how much do you trust the person you get drugs from?'

As always, the survey is encrypted, anonymous and confidential and we don't collect IP addresses. The first time anyone sees the results is when our media partners share them in May 2019.

To take part in the world's largest drug survey, GDS2019, visit www.globaldrugsurvey.com/GDS2019

The authors are members of the GDS Core Research Team

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.

'It is a cause for concern that these deaths will not appear on any national statistics or discussion around drug deaths in the wider press.'

FALSE PICTURE

At the recent meeting of the Drugs, Alcohol and Criminal Justice Cross-Party Parliamentary Group, the subject of drugs deaths was discussed again, and the ONS reported a tiny fall in the number of deaths reported as 'drug poisoning' in 2017, after a period of year-on-year rises. While any decrease in the number of drug deaths is to be welcomed, I cannot help but worry that these figures paint a false picture of a much grimmer reality to the wider world.

In the past two weeks I am aware of three individuals who have sadly passed away in West London. The causes of death will be recorded variously as heart failure, asthma attack or possibly even natural causes in one case, and yet in each instance there is no doubt the major contributing factor to these early and untimely deaths was a long history of problematic substance use.

It is a cause for concern that these deaths, by no means unique and most certainly not uncommon, will not appear on any national statistics or discussion around drug deaths in the wider press.

If the reporting of drug deaths were to include those individuals for whom their substance use was a major contributing factor in their early demise, irrespective of the eventual cause of death, then I imagine you could increase the number of deaths recorded by a factor of ten, if not a great deal more.

Perhaps then we could have an honest discussion with the rest of our fellow citizens about the need for a properly funded treatment system, still lacking in so wealthy a nation. I for one am more than a little weary of adding yet more names to my personal Book of the Dead and quietly mourning those who should still be with us.

Tim Sampey, chief executive, Build on Belief

BE CAREFUL WHAT YOU WISH FOR

It's increasingly difficult to engage with any kind of media without coming across yet another opinion column extolling the virtues of drug legalisation and regulation, or some kind of 'debate' that pitches three pro-legalisers against some hapless lone defender of the status quo. It does now seem inevitable that we are ultimately heading in that direction, but I think it's a decision that we'll come to regret.

The catastrophic opioid epidemic in the US is largely the result of legal, prescription opioids, and no one with any sense really buys into the argument that legalisation will see a short spike in use that will eventually level out. What we'll see will be a free-for-all, no matter what spurious and ineffectual controls on advertising and marketing are put in place. And surely no one believes it will put the dealers and drug gangs out of business either? The Canadian government is proudly trumpeting the fact that you have to be over 18 to legally buy cannabis – which market do they think the dealers will be catering for, in that case?

Mephedrone, before it became illegal, was widely used by people who'd never taken drugs before, simply because it was easy to buy online and the 'legal high' status made it sound safe. After the Psychoactive Substances Act, rates of use plummeted. In the drug treatment field, it's easy to exist in a bubble and forget that most people don't actually know any drug dealers or have easy access to drugs. As the saying goes, be careful what you wish for.

Simon Fanning, by email

URBAN RECOVERY

In his article in last month's issue ('Adios Recovery Riviera?', DDN October, page 15) Mark Gilman questioned the wisdom of sending people miles away to rehab instead of supporting them within the community. Danielle Robinson **responds**

TRADITIONALLY RESIDENTIAL REHABS TEND TO BE LOCATED IN RURAL AREAS, by the coast, away from the busy towns and the inner city. The Acquiesce model of urban recovery simply means completing residential rehabilitation in an urban setting where there are triggers aplenty!

Acquiesce believes that recovery is not about living in fear and hiding away from the world, but supporting individuals to achieve their potential and live life to the fullest – and to learn to deal with triggers, we need to experience being triggered. For example, a simple everyday task like visiting the supermarket could result in relapse. There may have been an intention to enter to purchase food, but the sight of the alcohol aisle could act as a trigger. If this trigger is not managed, it could escalate.

The urban recovery model allows for individuals to recover in real life situations, while being in a secure and supported environment. They have the opportunity to gain the tools and experience necessary to recover, while maintaining a level of autonomy and responsibility over the process.

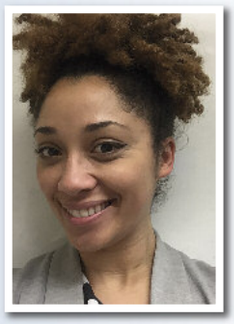
The model offers a philosophy of care that helps to ensure people are included in their families, communities, employment and education. We deliver this using a five-pronged approach of providing treatment for the psychological, physical, spiritual, social and family aspects of addiction, using a combination of evidence-based 12-step and therapeutic approaches.

Our outcomes evidence shows that individuals who access residential rehab in their own locality can successfully build their recovery networks where they live. You could travel to the opposite end of the earth to go to a rehab centre but you will still take yourself with you. We feel it is important to identify that dealing with addiction is an inside job as well looking at external factors.

Building your recovery capital locally can make leaving treatment a much less scary prospect, as you are leaving with a plan of support that you have already begun engaging with. Many individuals are at their most vulnerable as they leave a rural residential treatment facility to return to their community, as they have not built local recovery links and can feel like they are returning to their home town from their 'treatment bubble' only to start from square one.

Danielle Robinson is service manager at Acquiesce, www.acquiesce.org.uk

CLINICAL EYE



A MATTER OF VALUE

Attracting the right permanent nursing staff means offering quality of life, says **Ishbel Straker**

I AM GOING TO SAY SOMETHING THAT IS A LITTLE CONTROVERSIAL... I understand and empathise with agency nurses. Now don't shoot me down in flames, this does not mean I like the impact that agencies are having on our ever-decreasing budget, the lack of consistency with an agency nurse, or the resentment that people's perception of agency nurses can breed within teams.

What I mean by this statement is that I understand the attraction of working in this way and that we can't keep believing that agency nurses are simply after the money – which, by the way, I don't think makes them the void of morality that others seem to.

'I am going to say something that is a little controversial... I understand and empathise with agency nurses.'

With the well-publicised issues around the nursing pay increase – which was as disappointing as Theresa May's dance moves – the resignation of the Royal College of Nursing chief executive and the turmoil that is sinking us further and further with the bursary removal, nursing is not a government priority. This means that wages are poor for what we do, and the levels of stress we have resting on our shoulders and the hours we put in are not reflective.

Of course I understand why an agency is appealing when it can offer flexibility, better financial reward and, dare I say it, an ability to sleep better at night because the responsibility is significantly less. This sadly does our permanent staff no favours, as more weight rests on them and for less money.

So what is the solution? This needs to be a trust and organisational response and it needs to be consistent. The NHS attempted to remove the use of agency nurses – and did it work? No, because the trusts need staffing.

We need to talk to the nurses, discuss what they want, and have a really good look at the salaries – and I am not talking about 50p here and there. We need to consider the flexibility that is offered to them, not just from a rota perspective, but also when they are paid and how they can pick up extra shifts. Do they want progression? Possibly, but I don't believe you join an agency for this; you join for the reasons already stated, and that should be the focus.

We have to play the long game in attracting these nurses with realistic offers that will help to retain them, and make our services function with permanent staff who are proud to work for our organisations.

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

MEDIA SAVVY

The news, and the skews, in the national media

CANADA, AS WITH THE REST OF THE WORLD, has since the 1920s attempted to enforce a policy of prohibition urged on the rest of the world by its powerful southern neighbour...When Canada completes the legalisation of cannabis not even one of Donald Trump's famous walls will be able to stop it gliding south to the US.
***Independent* editorial, 17 October**

IF THERE IS A WHOLE SUPPLY CHAIN OF YOUNG PEOPLE whose lives have been damaged, that is because this government – and the majority of people in the Labour camp – prefer the ideological purity of criminalisation to any evidence-backed policy of harm reduction. Criminalisation, as is so often the case, is the problem not the solution.
Alex Powell, *Metro*, 3 October

WHILE COUNTRIES SUCH AS PORTUGAL are turning towards a more progressive, public health approach to drugs, our home secretary is trying to drag us backwards with punitive tactics. The war on drugs is an abject catastrophe that has been the cause of untold deaths and the facilitator of a thriving criminal market.
Emily Goddard, *Guardian*, 4 October

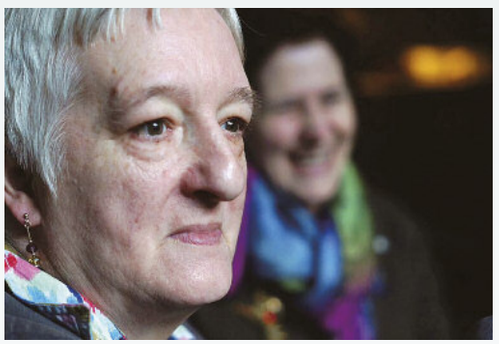
EVERY TIME I HAVE BEEN ON *QUESTION TIME*, the rehearsal question — the one not broadcast — has been about whether we should legalise drugs. And everyone on the panel and audience seems to agree that we should either do it right now or 'think about it'. There is always input from some skank on the public payroll who works with 'drug users' and will insist that legalisation would clear it up immediately and that we should never criminalise people with an 'illness'. What you choose to do with your life, then, is now an illness.
Rod Liddle, *Sunday Times*, 21 October

WITH NO MONEY TO PAY FOR REHAB BEDS, local authorities are reduced to doling out drugs themselves – for what is maintenance, if not competing with illegal drug dealers? The case for rehab is normally focused on the same calculus of cost-benefit that's led to their downfall. While it's true that properly rehabilitated addicts and alcoholics often become productive and responsible members of society, it's by no means always the case. Whereas maintenance programmes can often produce effective results in terms of lower reoffending rates and increased employability.
Will Self, *Guardian*, 17 October

WE WILL LOOK BACK and be utterly amazed that our top academic institutions tolerated for so long the taking of chemicals supplied by criminals. With cigarettes, initially we lacked the evidence that showed the harmful effects. On drugs, we already have the evidence. It is insane to let this continue. The tragedy is so many young lives have been destroyed while we were asleep to our responsibilities.
Sir Anthony Seldon, *Mail*, 7 October

THEY MADE THEIR MARK

The team at DDN were very sad to hear of the recent deaths of two 'harm reduction heroes' who made an impact on many. Activist and campaigner **Grant McNally** and **Beryl Poole**, much-loved peer advocate and a valued member of our DDN conference team each year, will be sorely missed.



Beryl, bless her, was a rare and true individual. I learnt a lot from her. *Steve Freer*

I'm very sorry to hear of the death of Beryl Poole - Another long-term harm reduction activist & friend of many. I'll miss your unassuming, self-deprecating, sometimes caustic wit – always, 'to the point' and down to earth. I'll also miss your Radio 4 recommendations and evident pleasure in having a grandson to spoil.
Gill Bradbury

Losing some of the greats in the drug user activist field hits hard. Beryl Poole & Grant McNally were passionate and kicked wide open the doors for me and others to walk through. *Anna Millington*

Beryl was the first woman I ever formally organised with back in 1996 setting up self-organisation of drugs users in Northwest London. Our Brent Substance Users Rights Forum met regularly at the Junction Project, enabled by Sebastian Saville who ran the agency at that time. Each group began with a Burning Issues session, in case anyone had been arrested, beaten up or had their scripts ripped away from them.

What I appreciated most about Beryl was her direction, always grounded in the reality of users' lives, plus she was passionate about learning the ropes, but I have to admit that I learnt more from her. She could also lighten the group up when things got too serious.

All her work with the Alliance: God knows how many people she supported there and all that work with DDN helping to organise the annual user conference. We have lost a great orator, carer, activist and comedienne.
Andria Efthimiou-Mourdant

Grant's work and his passing was recently remembered by many in a large HCV Community Summit in Portugal. Everyone was deeply saddened as many remembered the years of hard work Grant had put into the HCV awareness cause.

Grant was thought of by many around the world as a leading UK and European HCV activist and although his health took away much of his strength in recent years, he will always be remembered for his energy, insight and knowledge around bringing HCV awareness forward, indeed to the place it is today.
Erin O'Mara

Grant helped, and was held in high esteem by, people all over the world. *Nick Goldstein*

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KEEP ON MOVING

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