DDN

Drink and Drugs News
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A HAND UP

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CJ Wellings

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REGULARS

Evaluating synthetic cannabinoid detox

War on drugs complete failure

'The savings offered by HAT give an obvious direction'

MANY YEARS AGO the UK treated heroin addiction as a medical issue, with diamorphine scripts dispensed by GPs. It's taking us a long time to come back to that viewpoint but what might change the political mindset is the economic good sense of heroin assisted treatment (HAT, page 8). The savings represented by each person involved in the programme are significant and give an obvious direction.

Hopefully the summits being held by the UK and Scottish governments (as we go to press) will not ignore the evidence from here and abroad. Investing in treatment programmes – that not only offer the appropriate medication but also essential 'wraparound' services – would have a powerful impact on these devastating statistics and a transformational effect on quality of life.

A participant in the Middlesbrough HAT programme comments that he has tried all kinds of things over two decades, in and out of prison, and wasn't expecting this to work 'but then it was just unbelievable, how different it is.' The GPs at their recent conference (page 12) also threw their weight behind this evidence-based harm reduction, so what are we waiting for?

See you at our conference on 18 March!

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

Illegal drugs market has 'never caused greater harm', says Carol Black review

Even if more money became available for drug treatment, there would still be 'a lot of work to do' to build up capacity and expertise.
Professor Dame Carol Black

The illegal drugs market 'has long existed but has never caused greater harm to society than now', according to the first phase of Professor Dame Carol Black's *Independent review of drugs*. Even if more money became available for drug treatment, there would still be 'a lot of work to do' to build up capacity and expertise, the document adds.

Professor Black was appointed by the government to lead a wide-ranging review into drug harm (*DDN*, March 2019, page 5). Published in a week that saw rival drug summits held in the same Glasgow venue by Scottish and UK governments increasingly at odds over drugs policy, the phase one report says that increased funding for treatment is vital as a 'prolonged shortage' has resulted in a loss of skills, expertise and capacity.

The illicit drugs market is worth around £9.4bn per year, it states, and not only are drug deaths at an all-time high but the market has become 'much more violent'. The report estimates the health harms, cost of crime and wider societal impact to add up to almost £20bn, 'more than twice the value of the market itself'. The county lines model has meant that young people and children have been pulled into drugs supply on 'an alarming scale, especially at the most violent end of the market', with strong associations with increases in child poverty, school exclusions and the number of children in care.

In terms of treatment, funding pressures have led to the disappearance of some services and rationing of others, with similarities to adult social care. 'Providers have been squeezed, staff are paid relatively badly and there has been high turnover in the sector and a depletion of skills, with the number of medics, psychologists, nurses and social workers in the field falling significantly.'

Phoenix Futures welcomed the report and stated that 'drug use costs the country £20bn a year and only a mere £600m of that is in treatment. Communities across the country deserve better.' Collective Voice added that it was 'deeply concerned' by the document and called for a reverse in 'the funding cuts that have devastated addiction services over the last eight years and blighted the lives of so many people.'
Review at www.gov.uk

Cannabis legalisation a 'mental health risk'

MOVES TO LEGALISE CANNABIS risk 'fuelling the nation's mental health crisis', the charity Rethink Mental Illness has warned. While it recognises the 'strong arguments' for legislative change, more needs to be done to determine if legalisation would increase levels of public harm, the charity states, as use of high-potency cannabis can increase the likelihood of developing psychosis. It is urging policy makers to make sure that the debate around legalising the drug for recreational use reflects the possible impact on the most vulnerable and those living with – or at risk of – severe mental illness.

'We recognise the problems with the current law,' said deputy CEO Brian Dow. 'In seeking to overcome the current problems of criminalisation, we must guard against inadvertently creating a public health emergency. This debate has already been given a lot of airtime, but people are less eager to confront the potential impact of legalisation on some of the most vulnerable people in society. We need to redefine the debate.'

People are less eager to confront the potential impact of legalisation on some of the most vulnerable people in society.

Alcohol commission will look at bigger picture

A NEW COMMISSION ON ALCOHOL HARM will hear from professionals, charities, researchers and people affected by alcohol personally or in their family life.

The commission has been established in the absence of an up-to-date alcohol strategy for the UK, says the Alcohol Health Alliance. 'Alcohol plays a huge part of the everyday lives of many people across the UK, and therefore it is important to examine its impact on our society more closely,' said commission chair Baroness Finlay of Llandaff. 'We need to understand how our drinking habits affect our own health as well as the way alcohol can affect those around us. We welcome the input of those who face the effects of alcohol harm in their professional or personal lives in order to help us make meaningful recommendations on a vision for the future.'

Roger Harris

We welcome the input of those who face the effects of alcohol harm in their professional or personal lives.
Baroness Finlay of Llandaff

See news focus, page 6

Acabashi, Creative Commons

Alcohol-related hospital admissions up 20 per cent in a decade

Alcohol was the main reason for almost 360,000 hospital admissions in 2018-19, according to figures from NHS Digital – a 6 per cent increase on the previous year and 19 per cent up from a decade ago.

The figures are based on the narrow measure of instances where an alcohol-related disease, condition or injury was the primary reason for admission. Using a wider measure that includes conditions that could be caused by alcohol the number rises to 1.3m admissions, 8 per cent up on the previous year.

Alcohol-related primary hospital admissions accounted for 2 per cent of all admissions, with more than 40 per cent of patients aged between 45 and 64. More than 60 per cent of the admissions were men. Last year saw 5,698 alcohol-specific deaths, which is 2 per cent down on the previous year.

The Alcohol Health Alliance, meanwhile, is urging the government to increase alcohol duty in this month's budget to fund 'thousands of new jobs' in health and public services. The alliance is calling for an increase of 2 per cent above inflation – recent cuts in duty have cost the Treasury more than £1bn per year, it says, enough to fund the salaries of 40,000 nurses.

'Alcohol is 64 per cent cheaper than it was thirty years ago, and its availability at these prices is encouraging more of us to drink at unhealthy levels,' said alliance chair Professor Sir Ian Gilmore. 'In order to protect the future health of our society, the government must take action now by increasing duty on alcohol and investing that money into our over-stretched and underfunded NHS and public services.'

Statistics on alcohol, England 2020 at digital.nhs.uk

Alcohol Health Alliance letter to the chancellor at ahauk.org/letter-to-the-chancellor

Loneliness pushing people towards alcohol

MORE THAN ONE IN TEN PEOPLE who experience loneliness are turning to alcohol to cope, according to you a YouGov survey commissioned by Turning Point. Around 30 per cent of Britons feel lonely 'all, often or some of the time', the poll found – 35 per cent of women and 26 per cent of men – with people aged 40 and above most likely to drink to cope with their isolation. 'It's worrying that so many feel lonely, and some are turning to alcohol for comfort,' said Turning Point's head of psychology Jan Larkin. 'More commitment is needed from the government to addressing the issue.'

Meanwhile, provisional estimates from the Department for Transport (DfT) show a 4 per cent increase in drink-drive accidents for 2018. Almost 6,000 incidents involved at least one driver who was over the alcohol limit, resulting in around 240 deaths –13 per cent of all road accident fatalities.

Reported road casualties in Great Britain: provisional estimates involving illegal alcohol levels 2018 at www.gov.uk/government/organisations/department-for-transport

The right questions

ALMOST 90 PER CENT OF PEOPLE accessing Phoenix Futures' services have suffered a traumatic life event and more than a third have experienced sexual abuse, according to the organisation's latest *Footprints* survey. More than half have been homeless, 15 per cent were in the care system as a child and 70 per cent have been to A&E in the last year. Almost half, meanwhile, had found it 'difficult or very difficult' to find residential rehab information and funding, with 30 per cent of residents in one service having to attend a panel in an unfamiliar location in order to access funding.

> More than a third of people accessing Phoenix Futures' services have experienced sexual abuse.

'Every two years at Phoenix we ask the people who use our services the questions other people probably haven't asked them,' the charity says – 'questions that give us an understanding of the life lived before a person comes to us'. Locally designed processes are 'onerous and stigmatising and deter people from getting the help available' it adds. 'This creates a perception of "lack of demand" which impacts national and local policy decisions.'

Survey findings at www.phoenix-futures.org.uk

Local News

ASPIRE TO LEARN

Doncaster-based Aspire Drug and Alcohol Service has joined forces with the universities of Sheffield and North Carolina on a two-year behavioural activation study on substance use and depression. 'Being involved in this type of research puts us at the forefront of trialling new treatment interventions and patterns of care for people who use our services in the future,' said service manager Stuart Green.

GET THE EDGE

The winner of this year's Outside Edge Theatre Company competition for scripts about addiction will receive a £6,000 commission and mentoring from playwright Edna Walsh, the company has announced. Entries are invited from 16 March, with full details at *edgetc.org* and at the *DDN* Conference, which will feature a performance from the group.

HIV HELP

Change Grow Live is leading a new HIV partnership project in London to boost testing and help more people stay on treatment. 'HIV infection has a huge impact on vulnerable people including those with substance misuse problems,' said director Gaby Price. 'This partnership is an excellent opportunity to promote collaboration across the HIV and substance misuse sectors.'

OUT OF COMMISSION

With the government's long-awaited alcohol strategy showing no signs of materialising any time soon, the newly launched Commission on Alcohol Harm is hoping to fill in some of the gaps

It's estimated that alcohol harm costs the NHS around £3.5bn a year, with alcohol-related hospital admissions up 20 per cent in a decade (see news, page 5). The cost to the wider economy, meanwhile, is thought to be anything up to £21bn, all of which makes it odd that we've had no new alcohol strategy since 2012 (*DDN*, April 2012, page 4).

In response to this, a new Commission on Alcohol Harm has been launched by the Alcohol Health Alliance (AHA) (see news, page 4). The commission will hold three oral evidence sessions across the country, with these and submitted written evidence feeding into a wide-ranging report.

'I think it's time to re-focus the public's attention,' AHA chair Professor Sir Ian Gilmore tells *DDN*. 'The lack of a strategy is really harming the nation, and it's timely in terms of the pressures on the NHS.' While A&E departments used to feel the impact on Saturday nights, it's now every night of the week, he says. 'Then there are the chronic conditions and the links to cancer that maybe weren't so evident when the evidence was last reviewed. I think the spotlight also needs to be put more on areas that are traditionally less well known, like domestic violence, children of alcohol-dependent parents, and foetal alcohol spectrum disorder. I think it's time to look beyond the usual harms.'

The commission will make recommendations across the board, and not just about prevention – its scope also includes treatment services, which are 'of major concern', he says. 'But in terms of prevention we wish to be evidence-based, and the evidence is around price, availability and marketing.'

When it comes to marketing, two areas that are perhaps ripe for reform are social media and the current system of self-regulation around labelling. 'While the government hasn't been receptive to regulation I think they are concerned about digital marketing and protecting children, and alcohol falls very much into that category – so we'll certainly be making the case around the digital world,' he says. 'But also self-regulation doesn't seem to work, and I think that's something that's likely to come out of the commission.'

Any effective alcohol strategy will need to address price, and one thing it's easy to forget it is that the 2012 strategy did actually contain a commitment to minimum unit pricing (MUP). While that's now in place in Scotland – albeit after a lengthy battle – and Wales, we're still yet to see it in England. Gilmore believes the introduction of some sort of floor price is only a matter of time, however.

'I think the evidence is overwhelming that price is the single biggest determinant of how much communities drink,' he says. 'There isn't just one mechanism of tackling price, and I think the huge benefit of MUP is that it hits the cheapest drinks. Products like white cider have almost disappeared in Scotland since MUP, and very few moderate drinkers drink white cider – it tends to be the most vulnerable. So minimum unit price is certainly on our agenda as an important priority, in partnership with duty.'

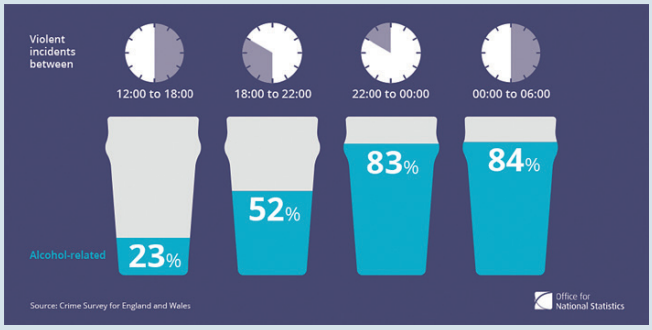
The drinks industry's first response 'is always, "It's nothing to do with price, we need to change the culture"', he says. 'But my response to that is the biggest change in culture in the last 20 years has been going from a country that drinks in pubs and bars to a country that drinks at home. About eighty per cent of alcoholic drinks except beer are drunk at home, and even beer is 50-50 whereas it used to be consumed overwhelmingly in pubs. That's been driven by cheap supermarket drink.'

Access to treatment, meanwhile, is 'worryingly inadequate', he says, 'and our impression is that it's getting worse rather than better. Services are getting more fragmented and often put out to the lowest tender, and while I understand the reasons for moving public health into local government there have been casualties from that in funding terms.'

So what are his hopes for the commission? 'What will we achieve? I don't know. But we know from experience that we won't achieve anything if we don't try, and we think the time is right. The lack of government commitment, the evidence of real progress in Scotland, the pressures on the NHS – they all make the commission a timely exercise.' **DDN**

'It's time to re-focus the public's attention. The lack of a strategy is really harming the nation, and it's timely in terms of the pressures on the NHS.'

PROF SIR IAN GILMORE



The government estimates that alcohol-related harm currently costs the NHS £3.5bn every year (equal to £120 for every tax payer) and the wider UK economy £21bn – more than double the £10bn revenue generated from alcohol taxes.

www.ahauk.org

ACCESS ALL AREAS

Phoenix Futures' Scottish Residential Service is transforming life for clients with disabilities, explains **Lyndsey Wilson-Haigh**

Almost 14m people in the UK are recognised as disabled according to government data, with 20 per cent of the working age adult population falling into this category. This rises to 30 per cent for those within the recovery community, reflecting the prevalence of long-term physical health risks associated with substance misuse. At Phoenix Futures we passionately believe in challenging barriers to recovery, and work to ensure as many people as possible receive the treatment they need to change their lives.

The Phoenix Futures Scottish Residential Service offers a therapeutic drug and alcohol treatment programme within a highly accessible environment. We can provide for people with limited mobility, people who use wheelchairs who can self-transfer, and we can make reasonable adjustments to support people with visual and hearing impairments. The service is delivered from a building with ground-floor bedrooms and a lift to access upstairs rooms. We assess the needs of all potential community members on a one-to-one basis to ensure we provide a full programme of support. This is managed through a robust risk assessment and management planning process which is reviewed regularly throughout the programme.

When the Scottish Residential Service relocated in 2018 we actively sought and refurbished a building which could help and support people with a wider range of needs. We had received feedback from a number of people who use wheelchairs and who were eager to access recovery but were struggling to find a residential programme in a suitable environment. Danny detailed this in his story. 'I'd been given funding six months before I got a place at Phoenix Futures but no place would take me,' he says. 'I'd lost hope on everything.'

Sadly, Danny was not alone. Karen too had faced challenges in finding a programme to accommodate her. 'I had previously looked at another rehab but they couldn't accommodate my needs and they were not wheelchair accessible,' she says. 'So, when the hospital addiction worker mentioned Phoenix I didn't believe them as I didn't believe there was somewhere like Phoenix that existed.'

'I'd been given funding six months before I got a place at Phoenix Futures but no place would take me. I'd lost hope on everything.'

Thankfully, our new service has been able to improve access to recovery for many people who use wheelchairs and for those who have limited mobility and/or complex physical health needs. The building has been purpose-designed to remove restrictions and promote inclusiveness, and the wheelchair-friendly environment ensures we maintain high standards of accessibility throughout the service.

'The building here is perfect for my additional support needs,' says Danny. 'There is nowhere in the building that is not accessible and this allows me to be a full member of the community. This gives me the belief that when I move on, being in a wheelchair will not hold me back.'

The service can accommodate up to 31 community members, with each room fully accessible and inclusive of its own en-suite wet room/bathroom. Adaptations can also be made to bedrooms, such as bed supports, toilet aids or grab bars. The service works in partnership with occupational health teams to ensure each individual has access to any aids required, and guide and assistance dogs are welcome.

There are large, open social spaces and group rooms, along with designated gender-specific rooms and social lounges with low-level access throughout. The programme offers a range of in-house activities and interventions as well as health and wellbeing activities including music, performance, swimming and arts and crafts. 'When I got there the building blew me away, everything was accommodated for me,' says Karen. 'There's nothing I cannot do, I have come on leaps and bounds. I participate in everything including external activities.'

'Phoenix has provided me with the opportunity of recovery and I was proud to complete my detox,' adds Danny. 'I have also been supported to get the medical help that I needed and I am in a much better place physically. I now participate much more in groups where I build my confidence and develop the tools I need to get better.'

Despite having been in our new home for just 18 months, the programme and skillset of our team members have developed at a tremendous pace and we've welcomed several community members who previously might not have found access to a complete programme. This is just the beginning of our exciting new chapter – making accessibility an option, not a barrier.

www.phoenix-futures.org.uk

A HELI

Heroin Assisted Treatment (HAT) is showing dramatic progress in transforming lives. **DDN** reports

'Life was shit. I would rob Peter to pay Paul. I'd cry every day and was at rockbottom, living on people's settees, doing drugs whenever I could.' 'Julie', Middlesbrough, 2020

If Julie was living in middle class society in Britain before the 1960s she might have been prescribed heroin for her addiction problem. Until the Dangerous Drugs Act of 1967, this was seen as a suitable treatment, but overprescribing by doctors and diversion to illicit markets changed all that.

The preferred treatment became newly developed oral methadone – a more comfortable option for doctors and clinics to prescribe, as it was specifically for 'addicts'. Via the Misuse of Drugs Act 1971, heroin became class A – among the most 'dangerous' drugs.

The new wave of heroin use in the '80s spread throughout Europe, accompanied by the spread of HIV and AIDS. While Britain was an early adopter of harm-reduction measures including needle exchange, oral methadone was established as the main form of maintenance prescribing.

Switzerland tried a different approach to harm reduction, and in the early 1990s the government allowed a new heroin assisted treatment model – HAT. The idea was to offer a reliable supply and clean injecting equipment, and to combine it with healthcare and access to services. The medical grade heroin was seen as the best incentive to engage people with treatment.

The first Swiss HAT clinics opened in 1994 as part of a three-year trial, which was then expanded with public support. Participants' health was found to have improved significantly – and crucially for the viability of the project, their criminal activity had decreased, giving net savings on the cost of their treatment. Members of the public were keen to see the programme continue as it reduced drug use on the streets, while medicalising heroin had the added benefit of reducing its appeal to young people.

By 2009 Germany and the Netherlands had conducted their own trials and included HAT in their health systems. A German study showed significant long-term improvements in mental and physical health after two years, and the EMCDDA concluded that HAT could lead to 'substantially improved' health and wellbeing.

A decade later, the year-on-year increase in drug-related deaths has prompted the UK to reconsider the evidence. At the RCGP/SMMGP conference in January, Dr Saket Priyadarshi explained that HAT had been incorporated into Glasgow's new Enhanced Drug Treatment System (EDTS).

'We've been making the case for a long time without getting traction politically,' he said. The game changer had been an outbreak of HIV, where the common factors were injecting heroin and cocaine in public spaces. A report, *Taking away the chaos*, led to a formal health needs assessment and brought in the international evidence – and among the recommendations were

'The participants had committed 943 crimes that were detected at a cost of £3.7m – you can see how the arguments stack up in support of this scheme.' PCC Barry Coppinger

'James' talks to BBC Tees reporter Andy Bell: 'This might not work for everyone, but it's worked for me and for the other people on the programme. There's not many of us on it but it's the chance of a lifetime and you can see the difference in everyone.'

PING HAND

safer injecting facilities and HAT.

The drug consumption room immediately stumbled into difficulties over its legality – 'we needed to make a case for it within the existing legal system', which involved talking to Westminster. Meanwhile the drug-related deaths crisis was escalating, so an interim plan looked at implementing HAT.

'We wanted to show we were offering a whole range of interventions, not just HAT,' said Priyadarshi. 'So we based the service in Glasgow city centre in the building of a homeless service.' It was refurbished to be 'clinically effective' and to also 'reassure the Home Office that we were running a professional and safe service'.

Referrals came from the homeless addiction team and the criteria related to real life, he explained, unlike the stringent criteria of the RIOTT trials, which required being abstinent –'we wouldn't be able to recruit a single person!'.

With a pre- and post-injection assessment, injecting takes place twice a day in one of four booths. Crucially, while they are there visitors are offered injecting equipment, wound management and naloxone. In the pharmacy at the back of the EDTS, the controlled drug cupboard is operated by fingerprints and monitored by CCTV, and there is a research and evaluation programme running alongside the service. 'We've gone overboard to show we have safe procedures,' he said.

The first patients – all with 'severe and multiple disadvantages' began treatment last December. Their two doses a day at 300mg-400mg have achieved stabilisation, during which they were introduced to wraparound services, including the BBV and mental health teams. Their immediate health and welfare needs were assessed, with the offer of help with everything, from housing to looking after their toenails.

Outcomes evaluation so far shows a 'very promising treatment option', particularly for people who have been going in and out of prisons and hostels for years. Also, crucially for its chance of sustainability, it shows that the service has already recouped the spend through saving on hospital admissions, multiple arrests and all the other costs that accompany a 'complex needs population'.

Meanwhile the North West of England is equally desperate to change its reputation of having the highest number of drug-related deaths in England. At the end of February, a team from Middlesbrough proudly announced 'life changing' early findings from their 12-month pilot HAT programme, which has been running since October 2019.

Twice a day, seven days a week, the 11 participants come to a facility at the GP practice to inject a dose of medical grade diamorphine, under the supervision of trained staff. They are then offered access to a range of support services.

'Julie': This has given me a life

When I got the phonecall to be on the programme I refused first of all. I thought it would be like another methadone treatment – get put on it and then 15 years down the line still be on it.

I was a big shoplifter and doing a lot of drugs – I just thought it wouldn't work. I just can't believe how quickly it has worked. I don't touch the heroin at all, and I was doing it for 20 years.

This course has given me a life. I have disrupted my kids' lives a lot through the drugs, and my husband's life. This is my last chance and I know I'm on the right path.

This by itself wouldn't have worked but everything with it, it's working a dream. It's not just the two doses a day – it's much more than that. The nurses who are there with us, you can speak with them anytime and it helps a lot. They're there with you.

> 'This course has given me a life. This is my last chance and I know I'm on the right path... at first it was scary but we work together.'

At first it was scary for everyone, but now we all work together, it's a team. This is just the beginning – I'm not even close to being recovered yet. It's a scary little ride that I'm on, but I'm strapped in.

Above: 'One of the anxieties we had was that the individuals we approached were leading extremely chaotic lives with very little structure, and we were asking them to adopt a very structured life.' Clinical lead Danny Ahmed.

'It wasn't about selecting this cohort and setting up a separate centre for them, it was about how can we include these guys in a programme that has failed to benefit them historically,' clinical lead Danny Ahmed told *DDN*. 'We felt that heroin assisted treatment and its strong evidence base was a key way to start work with this difficult to reach group.' Putting the clinic in an existing treatment service gave participants the opportunity to engage with all the partner organisations within the medical practice.

'One of the anxieties we had was that the individuals we approached were leading extremely chaotic lives with very little structure, and we were asking them to adopt a very structured life,' he said. The team's worries were allayed – the attendance rate has been 99 per cent. And because they were there every day, they have been able to help them with leg ulcers and other chronic health conditions.

Some of the participants were street homeless when they joined the programme, but have now had support to get into accommodation. All of the participants have reported improvement in their own perception of their health and wellbeing. Ahmed has known some of them for 20 years while working in substance misuse in the area and is 'privileged to see the progress' as they physically change. 'They look brighter, they've gained weight, they're starting to look really, really well.'

Patients receiving two doses a day at 300mg-400mg have achieved stabilisation, and have been introduced to wraparound services, including the BBV and mental health teams

The cost of the medication is around £5,000 per person per year, and PCC Barry Coppinger, who actively supports and joint-funds the project with Foundations Medical Practice, Durham Tees Valley Community Rehabilitation Company, Tees and Wear Prisons Group and South Tees Public Health 'would love to see the scheme rolled out to the other boroughs in Cleveland'.

He compares this cost with the savings to the taxpayer. 'The participants had committed 943 crimes that were detected at a cost of £3.7m – you can see how the arguments stack up in support of this scheme,' he says. 'So we're hopeful that we can continue to make progress, and I'm going to use the proceeds of crime income that I get from seizing assets from criminals to underwrite the scheme as we go forward.'

The next step is to convince the Home Office (who licensed the project) and the neighbours – and the neighbours' neighbours – that the project and its progress could be expanded beyond Middlesbrough.

'I continue to be impressed with the overwhelming change in our participants in such a short timeframe,' says Ahmed. 'The majority have battled addiction for decades and they are finally able to lift their heads out of the daily struggle of substance use and look forward to living life.' **DDN**

This article has been produced with support from Ethypharm, which has not influenced the content in any way

'James': Last roll of the dice

I never went without drugs since 1999. I spent a lot of time in jail, but I still used in there as well. I came into this with a roll of the dice to see if it does work, because I've tried other things – all kinds over those two decades. I thought this can't hurt, but I wasn't really expecting it to work. But then it was just unbelievable, how different it is.

I used to shoplift to feed my habit. Before I started this programme I needed at least £40 a day to feed my addiction – £40 that I could sell it for, so I'd need £80 of stock a day. I don't need to do that now. I've even had a security guard say to me that they've noticed the difference!

About 9 or 10 o'clock I'd run to the town, to Boots or one of the bigger shops for wash stuff or toiletries. I'd fill up a bag for life with as much stuff as I could and get out of that door, no matter who I had to push out of the way.

Then I was going to sell it, getting half price of whatever it cost in the shop. I'd go and get some more gear to get me over till the afternoon, then I'd head back into town again. I'd go somewhere for a couple of pairs of jeans, then to House of Fraser or Debenhams for a few of their Lacoste t-shirts. I'd go back out and sell them and that would get me to about teatime, and about five-ish I'd head back to town for the last half hour rush because everyone wants to get home then. This time I didn't care who was there, even if there were staff, I'd fill up the bag in front of them and run to that door. I'd sell that stuff as quick as I could and that would be my night-time gear.

You weren't looking to the future – you were looking to the next injection or whatever you could get. I can see now I've got a future, I can see the direction I'm heading.

'I used to shoplift to feed my habit. Before I started this programme I needed at least £40 a day to feed my addiction.'

This might not work for everyone, but it's worked for me and for the other people on the programme. There's not many of us on it but it's the chance of a lifetime and you can see the difference in everyone. I hope other people can have the chance I've been given.

They said what..?

Spotlight on the national media

WILL A BORIS JOHNSON government introduce drug consumption rooms? A supervised consumption facility would allow the Tories to be 'tough on crime' by pursuing drug dealers, but sympathetic to those in the throes of homelessness and addiction... At a time when the opposition party has lost all but one seat in Scotland, surely the strategy for the Tories must be to capitalise on the low hanging fruit and facilitate the piloting of live-saving safer drug consumption facilities? ***Ant Lehane, Herald Scotland, 17 February***

Surely the strategy for the Tories must be to capitalise on the low hanging fruit and facilitate the piloting of live-saving safer drug consumption facilities?

A TRANSATLANTIC SCHISM has opened up over vaping and health. In the US, the war on vaping is being pursued by activists, politicians and scientists who believe that tobacco companies are cynically promoting e-cigarettes as a means to get people addicted to nicotine, which will – sooner or later – lead them to cigarettes. In the UK, anti-smoking campaigners and health experts counter that for many adult smokers, vaping offers the best hope of avoiding a premature death. The two sides periodically break into open hostilities. The claim by PHE that vaping is 95 per cent safer than smoking tobacco, frequently quoted by e-cigarette manufacturers and sellers, has been criticised as misleading by anti-smoking campaigners in the US... Many public health experts in the UK believe they are witnessing an unnecessary tragedy, and that failure to promote the most promising method of helping people quit smoking is endangering the lives of millions. *Sarah Boseley, Guardian, 18 February*

I KNOW THE DAMAGE short-term prison sentences do and I also know how ineffective they are. I've met too many people who are serving a life sentence in instalments, their addiction and mental health needs untreated, their trauma unaddressed and their housing, social support and employment broken over and over again. Our own addiction to imprisonment as the only response to crime feeds itself, repeatedly setting people up to fail as they return to prison. ***Karyn McCluskey, Scotsman, 24 February***

WHEN IT COMES TO DRUGS POLICY, California is the most fascinating large-scale experiment happening anywhere in the world — and it's well worth studying, given how legalising cannabis might affect tax revenues and the local economy and have unpredictable consequences for public health and the criminal justice system... One report suggests that cannabis sales in California hit almost £3bn in 2019, and that same year around 67,000 jobs in the state were estimated to be supported by the industry. That's all positive, but tax revenues have disappointed — raising less than a third of the roughly £1bn a year that had been forecasted. The main reason seems to be the extremely high tax rates California levies on legal marijuana — making it far cheaper to buy cannabis from an illegal dealer. *Rohan Silva, London Evening Standard, 6 February*

CHANGING THE RECORD

When we start treating people who use drugs as grown-ups we will start to get somewhere, **Adam Winstock** told the GPs' conference

'Policy has to accept that people are using alcohol and other drugs... most people who use drugs do so moderately.'

Running the Global Drug Survey (GDS) for the past five years had confirmed to Adam Winstock that we need to change our attitude and culture towards drugs. Participants in the GDS will 'pass the million mark' this year, 'the largest drug survey in the world'.

'Our role is to try and change the conversation,' he said. 'If we can encourage people to use less than once a month, rates of dependency are negligible. When you get to weekly use, dependency risk increases.'

So reducing people's frequency of use was a key outcome. Not only was this sound harm reduction practice, but also 'people who use safely get most pleasure'.

The more problematic areas were beyond GDS' sphere of influence – social inequality and deprivation. 'Once you've developed dependency you can't usually get back to safe use,' said Winstock. 'Zero tolerance drug policy doesn't allow us to help.'

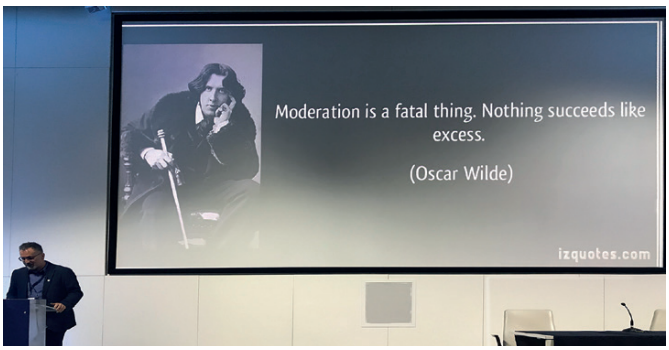
The latest drug strategy had continued to underpin failing policy. 'The slashing of funding is partly responsible for spiralling deaths,' he said. 'The drug-related death graphs are unacceptable in a developed country.'

To moderate people's use you had to tap into things they know, such as cannabis can affect your driving, or make you forget things.

'We need to treat drug users as grown up,' he said. Even the language around drug use 'puts distance between us and them... it dehumanises people'.

Furthermore, we should be moving away from what drugs people used to why they used them. British binge drinking had become a 'normative delusion', so 'if we want to encourage moderation, we need to look at motivation,' he said. These motivations needed to be age relevant – so for example health warnings for older people and embarrassment for younger people, who might readily identify with the 'risks of alcohol-related social embarrassment (ARSE)'.

'The current laws don't work – we need marketing messages that show how positive messages can use positive choices,' said Winstock. 'Messages that talk about zero tolerance do not change behaviour.'



A CHANGE OF

When a 'general in the war of drugs' calls the campaign a complete failure, it's time to listen. **DDN** reports from the GPs' conference

'The main casualties are the poorest, with not enough treatment and terrifying numbers dying – most of these preventable.'

Lord Charles Falconer

'The development of peer-led recovery communities has stalled. We need to find a way to kickstart self-sustaining systems.'

Dr Ed Day

'For the last 40 years we have been fighting a war on drugs. I've been a general. We sought to deal with it through the hammer blow of the criminal justice system and I am sorry for having supported this war. It has been an utter failure.'

Lord Charles Falconer was addressing an audience of GPs at the recent RCGP/SMMGP conference on managing drug and alcohol problems in primary care. The former minister under Tony Blair's government, whose roles had included justice secretary, said: 'It's time for us to acknowledge our failure and examine the evidence-based alternatives.'

'Addiction knows no class barriers – everybody knows somebody who is affected,' he said. Post-EU (and the conference was held on Britain's withdrawal day), 'the connection between those who know what they're talking about and politicians has to be restored.'

One of the most obvious ways of 'protecting the public from the cruel consequences of an obviously wrong policy' would be to legalise and regulate drugs, taking them out of the hands of criminals. He referred to the 1961 Single Convention on Narcotic Drugs, 'whose base was xenophobia', and the 1971 Misuse of Drugs Act, a 'pernicious policy' which the UK has continued to support 'even though it has brought death to thousands'.

'You only need to look at overdose deaths compared to those countries who have moved away from punishment, such as Portugal, to see this approach is catastrophic,' he said. Politicians were terrified of moving away from this approach because they were 'worried about being characterised as flip-flop wearing liberals'.

'We have produced some terrible soundbites – tough on crime, tough on the causes of crime', he said, and the reliance on prohibition as the main tool had 'gifted profit to criminals'. The main casualties had been the poorest, with not enough treatment and 'terrifying numbers' dying – most of these deaths preventable. Furthermore, we were trapped in a drug policy war: 'Every pound we spend on prohibition, the more we spend on clearing it up.'

So what could be the way forward? There was a clear need for evidence-based policy, he said, and we had to take a harm reduction approach that was 'holistic and non-judgemental', giving access to services.

'The government has to direct significant investment in drug services as a matter of urgency,' he said, with funding made available to ensure heroin-assisted treatment, needle exchanges, naloxone, and consumption rooms (on a pilot basis, with evaluation), as well as testing at festivals.

'The first priority must be to strengthen drug treatment services and develop harm reduction,' he said, 'and also improve the life chances of people who are recovering'. At the same time, we should review commissioning of services and look at improvements to the local model. He suggested setting up a central body for drug policy, reinstating a drug czar and considering a national agency to overview commissioning. The other vital call to action was to address the 'crisis in the drug treatment workforce', which included the drastic reduction in psychiatrist numbers.

'People are no longer interested in high blown rhetoric, they want solutions,' he said. 'If people don't like the way drugs affect their families and community, change will come.'

TEN YEAR ROLLERCOASTER

Six months into his role as national recovery champion, Dr Ed Day reflected on the run-up to his appointment and the progress he had been able to make so far. He was realistic about the capacity of his part-time unpaid role (alongside his other jobs), but also optimistic that his experience as a consultant addiction psychiatrist and knowledge of the sector contributed to evidence-based practice.

He talked of the 'rollercoaster' of the last ten years – first, the halcyon years of the Tony Blair decade, when there was a massive expansion of services around criminal justice and the advent of the NTA, 'which drove a real interest in the evidence base'. GPs were able to drive up the quality of prescribing.

Then came the 'crash' of 2008, followed

HEART

alcoholchange.org.uk

'When addiction psychiatrists retire, there will be no more in training. There are almost no psychologists in addiction anymore.'

Dr Emily Finch

nottinghambrc.nihrac.uk

'There are significant deficiencies in action with essential early diagnosis not happening.'

Dr Stephen Ryder

by the sweeping movement of recovery. 'The positives that came out of that included peer support – but somehow it was couched as against what we did before,' he said. 'We need to combine harm reduction and recovery.'

'We also need to try to change the system to a chronic care model,' he said, citing Maslow – 'you don't reach actualisation unless you have something stable underneath' – which could begin with needing methadone, for example.

The current threats loomed large – the reduction in budgets and turbulence in the commissioning system, combined with workforce issues that saw an exodus of skills and opportunities.

But 'in the rush to manage risk and KPIs we forget how to relate to people,' he said, with harm reduction and recovery both vital parts of the equation.

'The development of peer-led recovery communities has stalled,' he said, neglecting an opportunity for engagement and strategy. 'We need to find a way to kickstart self-sustaining systems.'

Peer-led initiatives could help to tackle stigma head-on: 'The real key is meeting someone who's had the problem and recovered,' he said. 'It's about giving people the key to change the situation themselves.'

HUGE AMOUNT OF INSTABILITY

Speaking in the final session of the conference about the future of addictions treatment, Dr Emily Finch referred to the 'huge amount of instability'. 'All addictions treatment tends to be in a silo in local authorities,' she said. 'People don't believe it when you say "we're not running that service anymore".'

There was also 'a real loss of skills in the sector'. 'When addiction psychiatrists retire, there will be no more in training,' she said. Constant retendering had contributed to their reluctance to enter the workforce, and there were 'almost no psychologists in addiction anymore'.

SURVIVAL FUNCTIONS

Dr Stephen Ryder, who gave a talk on liver disease, said that there was 'a mismatch between what industry wants and what health and social care wants'. The fact that England was 'still waiting for an alcohol strategy' demonstrated this, and he encouraged GPs to keep working on survival functions.

'The government won't do anything, so we have to do something,' he said. Despite high hospital admissions for alcohol-related diagnosis of liver disease, there were 'significant deficiencies in action' with essential early diagnosis not happening and more than half of people dying within two years of a late diagnosis.

In a conference called 'Navigating the storm' there was an atmosphere of battling through and looking for the patches of blue sky. But as seen in the conference message, the overwhelming response from GPs was – enough's enough. Health and sensible policy must be first priority in this cash-starved sector to stop the scandal of drug and alcohol related deaths. **DDN**

CONFERENCE STATEMENT

We deplore that in 2020 drug-related deaths are the highest on record and now a public health crisis.

We call on the College to work with policy makers to not criminalise people who use drugs and implement all evidence-based harm reduction measures to reduce drug deaths including consumption rooms and heroin assisted treatment for those who need it.

We call on the council to:

- *Recognise the devastating impact of lack of funding to drug and alcohol services since the 2012 Health and Social Care Act, with consequent destruction of shared care services and lack of workforce of those able to work effectively with people who use drugs.*
- *Support minimum unit price for alcohol as the single most important harm reduction measure to reduce health inequalities and save lives for people who have alcohol problems.*

SYNTHETIC SOLUTIONS

With research evidence around NPS still thin on the ground, a Nottingham service has been evaluating its synthetic cannabinoid detox protocol. **Dr Daniel Masud** reports

nzphotonz\iStock

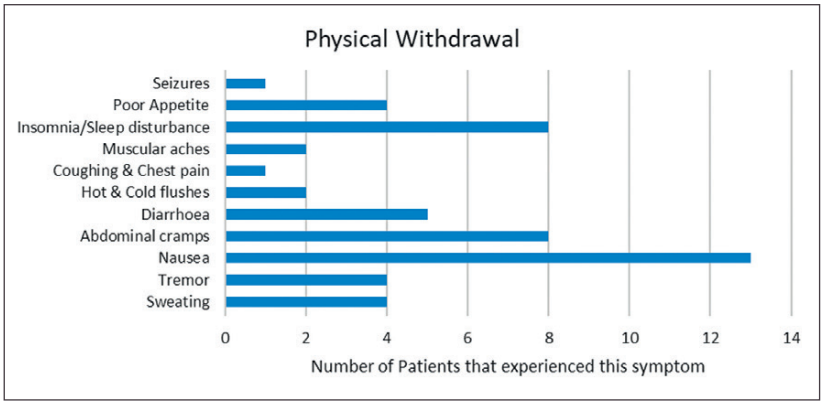
The research evidence on synthetic cannabinoids is currently limited to case reports and case series, as well as retrospective toxicology surveys, human and animal laboratory studies, and interviews with users. There are no longitudinal studies or randomised controlled trials.

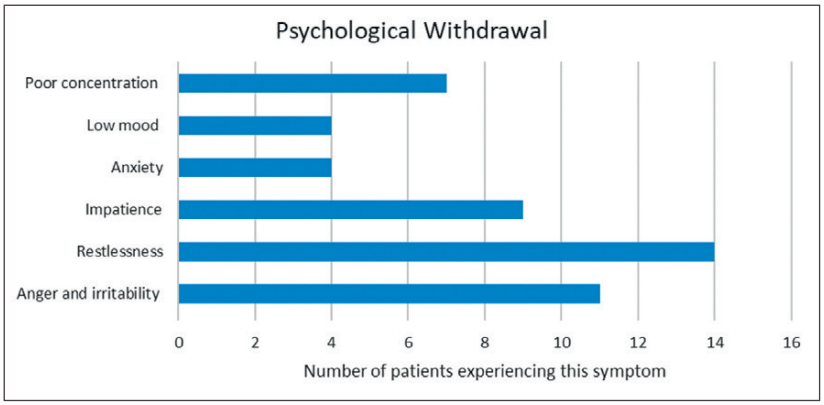
At Edwin house, a specialist care and reablement facility in Nottingham, our inpatient detox unit comprises 14 beds and our synthetic cannabinoid detoxification protocol is formulated by local clinician consensus on evidence gathered from Project Neptune and the Home Office.

Evidence to date indicates that chlordiazepoxide is the first-line medicine of choice to most effectively manage symptoms of withdrawal during NPS detox – this is prescribed on a variable dose-reducing regimen over a period of seven to ten days with additional chlordiazepoxide prescribed on an as-required basis (typically for the first 72 hours) to address more severe and acute withdrawal symptoms.

Since opening in 2018 Edwin House has admitted 22 patients who required detoxification for 'black mamba' NPS, and to assess the impact of the existing protocol we completed a retrospective case study analysis. There were 16 males and six females included in the study – more than half were in the 36-45 age group, with a further 27 per cent aged 46-55. Mamba was identified as the primary drug of choice and reason for detox in 18 patients and a secondary drug of choice in four. Across all 22 referrals additional substances were identified as 'problematic',

We were confident that withdrawal symptoms would be primarily physical, yet psychological withdrawal was also evident. Symptoms lasted from 24 hours in six cases to more than 72 in eight.





'Prior to this analysis we were confident that withdrawal symptoms would be primarily physical, yet psychological withdrawal was also evident. Symptoms lasted from 24 hours to more than 72. Patients respond to prescribed medicines in different ways.'

including heroin, crack and alcohol. The frequency that patients stated that they smoked mamba was variable – while three patients said they would only smoke it at night to induce sleep, nine said they smoked it every 30 minutes. Fourteen patients had been smoking the substance for two years or more.

Prior to this analysis we were confident that withdrawal symptoms would be primarily physical, yet psychological withdrawal was also evident. Symptoms lasted from 24 hours in six cases to more than 72 in eight. Patients respond to prescribed medicines in different ways dependent on a number of factors, including age, weight, lifestyle and not least the quantity, frequency and length of time the substance has been taken. During mamba detoxification patients reported the effect of their prescribed medicines – seven said the medication was 'very effective', while 13 said it had some effect.

All patients at Edwin House are encouraged to engage with the recovery team and participate in the group and individual sessions on offer – of the 22, only 13 participated in recovery-focused interventions. The nature of exit was also variable – 11 patients left in a planned and structured manner after successfully completing detox, while eight took their own discharge against medical advice for reasons including relationship problems or being unable to cope with the inpatient environment. Three were discharged for a breach of their terms of treatment – one for suspicion of smoking mamba, and two for disruptive and threatening behaviour.

While this case study analysis has proven to be a useful exercise it has failed to identify any clear and discernible patterns or trends specific to synthetic cannabinoid detoxification. A number of variables have influenced this, not least the additional substances being taken by patients, along with age and length of time they've been engaged with treatment services.

However, a successful detoxification completion rate of 50 per cent indicates that the existing treatment regimen offered can be effective, especially if the patient is prepared and has a robust aftercare and follow-up plan in place. Only one of the 22 had plans to relocate to rehab, however.

The intention now is to refine the analytical tool and embark on a further live study with patients via face-to-face interviews, perhaps on a daily basis as they undertake the process. This information could be recorded during drug dispensing on a pro-forma – data can be compiled in real time to identify emerging patterns, detect issues and pilot changes. Bespoke pro-formas will also allow us to capture useful measures such as morbidity, readmission rates, safety issues, length of stay, patient satisfaction, and waiting time to admission. It would also be prudent to consider a co-design for re-evaluation of our detoxification protocol – this could be achieved using live data, focused debriefs and focus groups.

Dr Daniel Masud is a psychiatric trainee based in the East Midlands


TREATMENT

WE NEED TO TALK ABOUT DIAMORPHINE

The new diamorphine programmes may not be the holy grail that some think, says **Nick Goldstein**

A MATTER OF TASTE

I'm very much in agreement with Nick Goldstein's assessment of diamorphine prescribing. Nearly two decades ago I used to buy diamorphine dry ampoules from someone who was prescribed by my local DDU because they preferred street heroin to pharmaceutical diamorphine. I also think he was probably not prescribed an adequate dose. And would you offer those who smoke heroin a similar choice? And in what form?

The cigarette injected with diamorphine prescribed in the '80s by Dr John Marks failed as they did not deliver a regular, measurable dose so a lot literally went up in smoke. Also heroin smokers are prone to developing COPD, which is as much a killer as overdose. However I'm unsure if these deaths would be recorded as drug related.

Users have their own particular taste for drugs across the range of psychoactive substances available. The NHS is unlikely to treat opioid dependent clients as a variation on a wine appreciation club.

Peter Simonson, London

UNFAVOURABLE ODDS

I was encouraged to see that the government has taken the long-overdue step of stopping businesses from allowing people to use their credit cards to gamble with money they don't have (*DDN*, March, page 5). This, coupled with the recent reduction in the maximum stakes on the malign FOBT machines suggests that things are finally moving in the right direction when it comes to gambling, although it would also be nice to see something serious done about the levels of advertising for this industry.

The cigarette injected with diamorphine prescribed in the '80s by Dr John Marks failed as they did not deliver a regular, measurable dose so a lot literally went up in smoke.

What is clearly needed now, however, is a corresponding – and substantial – increase in treatment provision. I know that budgets have been slashed across the board, but for far too long the level of available gambling treatment has been lamentable – calling it a 'postcode lottery' doesn't even cover it. I've long believed that the levels of problem gambling in this country represent a public health time bomb, and it's vital that provisions are put in place accordingly.

Howard Pearce, by email

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A CRUCIAL CO

Change Grow Live's National Naloxone Conversation event was a vital opportunity to keep up the momentum for widening access, says **Pete Furlong**

Our sector is very aware of the crucial need to increase naloxone access and availability nationally. Last year's ONS figures on drug-related deaths showed 4,359 fatalities related to drug poisoning in England and Wales, the highest number and annual increase – at 16 per cent – since the data set began in 1993 (*DDN*, September 2019, page 4). More than 2,200 had an opiate specifically implicated.

To address this need, Change Grow Live hosted a National Naloxone Conversation event in Manchester in January, bringing together professionals, activists, and naloxone peer educators to collaborate on new thinking and solutions to widen the availability of naloxone across the UK. Attendees also included Change Grow Live staff and clinicians, service user reps, Addaction (now We Are With You) clinical representatives and Red Rose Recovery staff, and all contributed to wide and varied discussions and planning for further development of naloxone interventions.

As harm reduction lead for Change Grow Live's North West region, it fell to myself and Zac McMaster – head of services for Change Grow Live Mersey and Cheshire region – to welcome more than 35 delegates from across the country. To set the scene, I outlined the journey our sector has been on over the last decade regarding take-home naloxone (THN).

Many of us have had to address the concerns of those who feared that the supply of THN would increase risk-taking behaviours among opiate users, but today we're able to point to a continually increasing global evidence base that naloxone saves lives. This, coupled with the need to urgently address the growing number of drug-related deaths, means that THN is now a core component of most new tender specifications and the majority of commissioners welcome more innovation in widening the availability of naloxone for those most at risk of opiate overdose.

We heard from Kirsten Horsburgh from the Scottish Drug Forum (SDF) about how Glasgow's peer supply programme, originally

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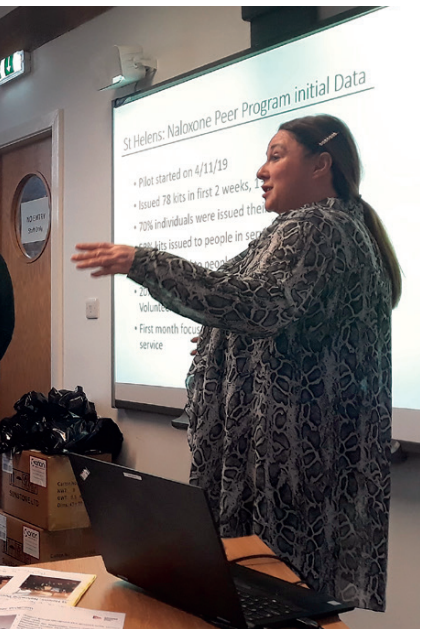
ONVERSATION



Above left: Kirsten Horsburgh from the Scottish Drug Forum (SDF) talks about Glasgow's peer supply programme.
Above: Rachel Fance and naloxone peers from the Change Grow Live St Helens service present initial findings and data from their pilot supply programme.

headed up by Jason Wallace and Steph Kerr, had not only had a significant impact on the numbers of naloxone kits issued across the city but had also reached new cohorts through peer supply and peer-to-peer education, with hugely impressive results. Kirsten also gave an overview of Scotland's priorities for harm reduction and naloxone supply, including the welcome news that paramedics are now set to issue kits to overdose casualties who refuse transport to hospital for further treatment and monitoring.

Last year I was asked to identify a service in the North West to pilot a peer-to-peer naloxone pilot, and I didn't have to think too long before recommending the St Helens Integrated Recovery Service, given their positive energy and the passion of the staff. On top of that, I was made aware that peer mentor John Pilkington had recently been alerted to a nearby overdose incident and had rushed from a waiting area where he was welcoming people with tea and coffee to successfully administer naloxone to a man in a state of respiratory failure. A powerful reminder, if ever one was needed, that naloxone saves lives.

It was therefore a proud moment for St Helens service manager Rachel Fance and local service user involvement lead Amanda Taft when naloxone peers from the Change Grow Live St Helens service presented the initial findings and data from their pilot supply programme. Rachel outlined the programme's structure and delivery, including the training and governance framework that had been developed, and described how the pilot had resulted in naloxone being used to save lives in the town centre on multiple occasions. The pilot is now looking to expand the recruitment of peer naloxone educators in the coming year, as well supporting and training them through increased education opportunities and the potential for secondary needle and syringe provision interventions.

The event also coincided with the end of Change Grow Live's six-month nasal naloxone pilot, which ran from August 2019 in Manchester, Knowsley and HMP Risley. As project lead, I was able to share a brief presentation of some initial findings and raw data. In overarching terms, the supply of nasal naloxone had been overwhelmingly popular with people using our services, with a significant increase in kits issued and interest from key stakeholders including hostels and law enforcement.

The potential for the local neighbourhood policing team in Manchester to be trained in the use of nasal naloxone is now under consideration following a successful pilot in Birmingham, and Change Grow Live's national research manager Zoe Welch will be working with myself and the leads from each pilot area to further evaluate the feedback, data and associated costs from the six-month delivery.

Zac McMaster led the afternoon session, which focussed on harnessing the potential of open source technology, while discussions also centred on what's needed for the development of effective peer-to-peer initiatives that can co-exist with statutory provision, with attendees identifying critical issues, concerns and new ideas to formulate actionable solutions.

The content of the day encapsulated the core principles of Release's best practice guide and the innovative work of EuroNPUD, with special emphasis on the importance of peer-to-peer naloxone initiatives involving people who use drugs and those with lived experience. Twitter helped in promoting the event, with great traction around the #naloxoneivegotmine hashtag, and we continue to strive for increased awareness of the need for naloxone to be available without barriers or restrictions in all areas of the UK.

There was a clear commitment from all involved to continued collaboration, starting with sharing the resources that have been developed in St Helens as well as all the material from the event. Our hope is that by maintaining this national community for ongoing naloxone conversations we will be able to help organisations to continually innovate. This community of practice will be unified by a shared commitment to meeting the ambitious but achievable target of 100 per cent of opiate users – as well as friends, family and loved ones – having easy and unimpaired access to life-saving naloxone as standard practice.

Any organisation or group that wants to be part of future events is welcome contact me at Peter.furlong@cgl.org.uk

Peter Furlong is North West harm reduction lead and development manager at Change Grow Live